Oxford City PCG and PCT:

A case study of collaboration

Alison Mairi Chisholm

This thesis is submitted in partial
fulfilment of the requirements of the
award of Doctor of Philosophy

Oxford Brookes University

April 2007

Abstract

In 1997 the New Labour government instigated a period of radical reform for the National Health Service, a key element of which was the establishment across England of Primary Care Groups (PCGs), which subsequently became Primary Care Trusts (PCTs). These were local statutory governance bodies with responsibility to deliver and develop primary care and to improve the health of their local population: complex functions requiring collaboration with a range of organisations and agencies.

The central aim of this study was to investigate whether and how PCG/Ts developed and facilitated collaboration within primary care, and between it and other NHS and non-NHS bodies, and to identify factors which enabled and inhibited collaboration. Using a theoretical framework which draws on a critical realist tradition, an approach was adopted to the analysis of organisational change which was attentive not only to rational, incremental processes of change but which took into account the political, cultural and economic context in which PCG/Ts operated. A key element of this context was the strong resemblance between New Labour's prominent 'third way' discourse of collaboration and the defining characteristics of a network mode of governance: trust, loyalty, reciprocity and voluntariness. Inductive and deductive approaches were combined to test and develop theory about the interactions between context and organisational form, using multiple qualitative methods within a longitudinal nested case study.

The study demonstrated that the locality-wide base of PCG/Ts, their explicit health improvement remit, budgetary arrangements and the presence of clinicians on their governing bodies were aspects of their organisational forms which equipped them to facilitate collaboration. However, over time, certain contradictions became apparent in New Labour's approach to organising the NHS which undermined many of the PCG/T's collaborative processes. This thesis argues that the alignment of the third way discourse with a network mode of governance exemplified 'symbolic politics.' What was presented as a rational response to complex social problems and fragmentation of public services, was in fact largely a pragmatic political manoeuvre designed to distance itself from the perceived failure of previous administrations' hierarchy and market modes of governance.

Acknowledgements

This research was funded as a CASE studentship by the Economic and Social Research Council, Oxfordshire Health Authority and Oxford City Council and supervised by Stephen Peckham. Thanks are due to everyone who facilitated my access to meetings and gave their time to be interviewed over the course of this study. I would particularly like to thank Professor Mary Boulton for her extremely helpful guidance, and Professor Caroline Glendinning who provided detailed comments on the thesis which have proved invaluable in substantially revising and redrafting it. The Picker Institute accommodated my sometimes inconvenient requests for study leave, for which I am also very grateful.

This thesis would not have been written without the rock solid support and love of my sometimes bemused family. I've had moral support along the way from many wonderful friends, among them Claire, Phil, Jim, Sandy, Toby, Esther, Jo, Danielle, Janet, Erica, Marie, Maria, Jess, George, Ruth, Harrie, Rich and Rover. Special thanks go to Lian for propping me up for far longer than we ever hoped she'd have to with her big-hearted, tolerant, unflagging encouragement, humour and faith in me. George - who was tricked into being with someone he thought had just finished her PhD - nobly spent much of the subsequent three years as coach, drinking beer and shouting inspiration, courage, solace and advice with a generosity I'll always remember and will do my best to match when his time comes..

Contents

Abstract ii

Acknowledgements iii

List of figures vii

List of Appendices viii

Chapter one: Introduction, context and overview 1

1.1 Background to this study 1

1.2 The PCG and PCT 2

1.3 Collaboration 3

1.4 Aims and research questions 4

1.5 Theoretical framework 4

1.6 Structure of thesis 6

Chapter two: Context for collaboration 10

2.1 Overview 10

2.2 Importance of understanding the context 13

2.3 Outer context: changing role of the state 14

2.4 Outer context: wicked issues and the third way 18

2.5 Outer context: cultural and political complexity 23

2.6 Outer context: tensions in the third way 28

2.7 Inner context: local driving forces 33

2.8 Inner context: individual factors 35

2.9 Inner context: organisational factors 40

2.10 Summary 41

Chapter three: Organisational forms of PCGs and PCTs 43

3.1 Overview 43

3.2 PCG structure 45

3.3 PCT structure 55

3.4 Processes for health improvement 58
3.5 Processes for delivery and development of primary care 63
3.6 Research questions and analytic framework 66
Chapter four: Methods and methodology 73
4.1 The realist research paradigm 74
4.2 Design: longitudinal nested case study 77
4.3 Methodological approach: multiple qualitative data 79
4.4 Interviews: strengths of the in-depth semi-structured case-study method 81
4.5 Observations: strengths and limitations of observing meetings 91
4.6 Documentary analysis 93
4.7 Ethics 94
4.8 Data analysis 97
Chapter five: Health improvement 109
5.1 Overview 109
5.2 Organisational structures of Oxford City PCG and PCT 114
5.3 Health improvement remit 118
5.4 Locality-wide primary care organisation 127
5.5 Practising clinicians elected by peers to governing bodies 137
5.6 Local authority representation on governing bodies 141
5.7 Summary 154
Chapter six: Primary care development and delivery 161
6.1 Overview 161
6.2 Locality-wide primary care organisation 166
6.3 Practising clinicians elected by peers to governing bodies 170
6.4 Shared responsibilities and corporate behaviour in primary care 181
6.5 Local authority representation on governing bodies 186
6.6 Summary 192

Chapter seven: Nested case studies 198

7.1 Overview 198

7.2 Introduction to the nested case studies 202

7.3 Health improvement remit 203

7.4 Locality-wide primary care organisation 207

7.5 Clinical governance, board composition and budgetary arrangements 218

7.6 Summary 229

Chapter eight: Discussion and conclusions 233

8.1 Overview 233

8.2 Critical evaluation of the PGC and PCT as mechanisms for collaboration 235

8.3 Theoretical framework 241

8.4 Strengths and limitations of the study 243

References 246

Appendices 263

List of figures

Figure 1: Realist theoretical framework 5

Figure 2: Realist theoretical framework – context 10

Figure 3: Realist theoretical framework – organisational form 43

Figure 4: Structure of generic Primary Care Group 46

Figure 5: Structure of generic Primary Care Trust 56

Figure 6: Analytical framework 71

Figure 7: Factors which guided selection of participants 86

Figure 8: Realist theoretical framework – collaborative capacity 109

Figure 9: Structure of Oxford City PCG and related NHS and local authority bodies 114

Figure 10: Structure of Oxford City PCT and related NHS and local authority bodies 116

Figure 8: Realist theoretical framework – collaborative capacity 161

Figure 8: Realist theoretical framework – collaborative capacity 198

List of Appendices

Appendix 1: Sample letters of invitation 264

Appendix 2: Sample interview schedule & covering letter 267

Appendix 3: Sample information sheet 269

Appendix 4: Sample consent form 270

Appendix 5: List of participants 271

Chapter one: Introduction, context and overview

1.1 Background to this study

Following the election of the New Labour government in 1997, the National Health Service (NHS), and primary care in particular, underwent a period of radical reform. The policy discourse of collaboration surrounding these reforms was both ubiquitous and ambiguous. Exhortations to collaborate were presented as a response to complex social problems, and the fragmentation and inefficiency of public services. It was asserted that collaborative working would result in better services for patients.

A key feature of the reforms, details of which were published in the White Paper *The New NHS: Modern, Dependable* (Secretary of State for Health, 1997), was the introduction of Primary Care Groups (PCGs) and, subsequently, Primary Care Trusts (PCTs). PCGs and PCTs were local statutory governance bodies which were expected to facilitate collaborative working within elements of their primary care community, with other parts of the NHS and other organisations and agencies whose work related to health in its broadest sense.

Interest in this raft of collaborative healthcare policy and legislation was high, and presented an opportunity to examine its implementation. A bid for research funding was supported jointly by academics at Oxford Brookes University and strategic level public sector workers from health services and the local authority: a non-executive director of Oxfordshire Health Authority (OHA), a senior officer from Oxford City Council and an assistant director of the local social services department (SSD). The Economic and Social Research Council (ESRC) funded a CASE studentship to examine the effect of the implementation of New Labour's new policy initiatives on collaborative working. This joint bid, and wide-ranging commitment to support the project, underlined the shared academic and applied interest in this area of research.

The present study, which looked at the effectiveness of policy changes in developing collaborative primary care services and collaborative efforts to improve health, began in the autumn of 1999 following the introduction of the PCG in April of 1999. The transition from PCG to PCT took place earlier than had been anticipated at the outset of the study, and changed the nature of the

research: what originally set out to be a case study of one organisation became a study of two organisations and the process of transition between them.

1.2 The PCG and PCT

PCGs and PCTs were introduced as the basic building bricks of *The New NHS* (Klein, 2001), as mechanisms through which collaboration would be built for the delivery of primary care and the improvement of health. PCGs were set up throughout England and went live on 1st April 1999. These new primary care organisations were statutory local governance bodies which connected primary care providers in a locality and served an average population of 100,000. They were led by a governing board made up largely of primary care practitioners and a representative of the local social services department (SSD). By 2002, PCGs had all been superseded by PCTs which were organisationally more complex with more extensive responsibilities, powers and budgets.

The three main duties of both PCGs and PCTs were:

- delivering and developing primary care
- commissioning secondary care
- improving the health of their population (Department of Health, 1997)

This research examines collaboration in relation to the first and third of these duties. The delivery and development of primary care, and health improvement, were complex functions and required the co-ordinated input of a range of organisations and agencies, including primary health care teams (PHCTs), other NHS bodies and local authority departments as well as non-statutory agencies. The structures and remits of the PCG and PCT implied a capacity and responsibility to develop, promote, facilitate and enhance collaboration between these organisations in a variety of ways, and Department of Health (DH) guidance emphasised the responsibilities of PCGs and PCTs to do so. According to the White Paper *The New NHS: Modern, Dependable*, PCGs were to "better integrate primary and community health services and work more closely with Social Services on both planning and delivery" (Secretary of State for Health, 1997 para 5.9). The following year, the NHS Executive stated that "the involvement of local government in the governance of PCGs will underpin the establishment of new partnership between primary and social care" (NHSE, 1998 para 21) and that PCG boards

were to "bring together lay members, Social Services managers with doctors and nurses for the first time to share the governing responsibilities. A Primary Care Group will also need to build up its partnership with the wider local government authorities" (NHSE, 1998, para 24). PCGs' and PCTs' pre-eminent position within New Labour's collaborative agenda was unequivocal.

1.3 Collaboration

The New Labour government's rhetoric was peppered with references to collaboration, partnership, alliances and co-operation, but these terms were rarely defined in policy documents. A variety of such terms are used inconsistently and almost interchangeably by policy-makers and researchers to capture the notion of working together. Commentators such as Miller & Ahmad (2000), Powell & Glendinning (2002) and Sullivan & Skelcher (2002) have concluded there is no uncontested definition of partnership (Dowling et al, 2004). Many authors focus on the terminology's persistent defiance of a single definition. Ling, for example, claims the literature on partnership amounts to "methodological anarchy and definitional chaos" (Ling, 2000: 82).

Fewer authors have committed themselves to explicit definitions of the terms. One who has is Hudson whose definition of collaboration is that "separate but related organisations adjust their behaviour in some way that takes account of each other's interests" (Hudson 1999: 187).

Another is Glendinning who defines partnership as:

> a particular type of relationship in which one or more common goals, interests and/or dependencies are identified, acknowledged and acted upon, but in which the autonomy and separate accountabilities of the partner organisations can remain largely untouched (Glendinning, 2002:118).

On balance, *collaboration* is used to connote a broader range of relationships than *partnership*. In this study, I adopt the term *collaboration* and, drawing on elements of the two definitions above, define it as:

> a relationship in which two or more individuals or groups (which may be professional, occupational or organisational) adjust their behaviour in some way to pursue common goals, interests or dependencies.

This definition accommodates the challenges inherent in identifying the organisational boundaries of primary care and the PCG/T itself. It also allows that among the collaborative aims of the PCG and PCT were precisely to compromise the separateness of organisations' and professional groups' autonomy and accountability and to foster a sense of corporacy.

1.4 Aims and research questions

The aim of this research is to investigate whether and how the PCG and PCT developed, promoted, facilitated and enhanced collaboration within primary care, and between it and other NHS and non-NHS bodies. It involves a case study of two organisations - the PCG and the PCT in Oxford city - over a period of three years, focusing on collaborative working towards development and delivery of primary care, and health improvement. It sets out to evaluate the PCG and PCT as collaborative *mechanisms*, as well as to measure the *outcomes* of their collaborative efforts in terms of health outcomes or service developments.

The main research questions are:

RQ1. How far did Oxford City PCG and PCT act as collaborative mechanisms to develop and deliver primary care and to improve the health of its population?

RQ2. Which factors enabled collaboration to come about, and which factors inhibited collaboration?

These are developed into more specific research questions later in this chapter.

1.5 Theoretical framework

To address these questions, the study adapts Sullivan and Skelcher's (2002) framework which identifies three interdependent elements of the examination of a collaborative mechanism:

a) the context in which the PCG and PCT operate, in particular the driving forces for and against collaboration

b) their organisational forms (structures and processes)

c) their capacity for, and practice of, collaboration.

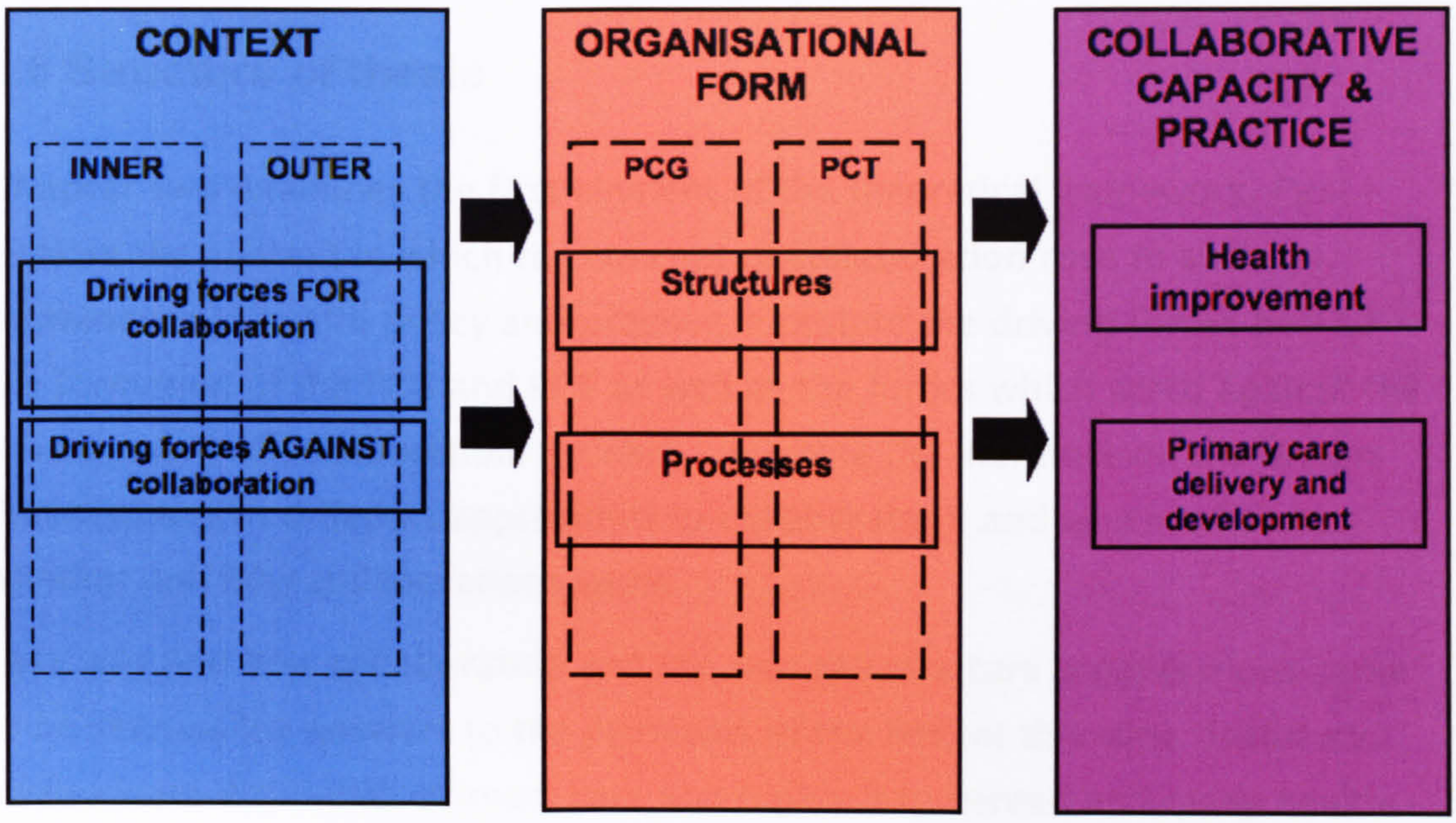

Figure 1: Realist theoretical framework

This study examines the driving forces for New Labour's collaborative agenda as manifest in the PCG and PCT, drawing on conceptual literature from two areas: first, political science to illuminate the national political, social and historical **context** in which New Labour was elected; and second, organisational science and sociology to identify the factors which exert more proximal influence on collaborative activity. Next I examine New Labour's policy response to the driving forces through government documents and guidance which set out the **organisational forms** of PCGs and PCTs, insofar as they were nationally prescribed. I then examine the organisations' **collaborative capacity and practice** through case studies of the PCG and PCT in Oxford.

Using this framework, the study asks how effective the two organisations were in achieving collaboration. What forms of collaboration were appropriate to the context in which they operated and their remits? Which factors of their organisational forms and the context within which they operated influenced how effectively they fostered collaboration both within primary care, and between primary care and other bodies for health improvement and primary care development?

1.6 Structure of thesis

Chapter two examines the first element of the theoretical framework. First I explore the context in which the concept of collaboration rose to such prominence in health policy and practice. I explore the driving forces behind the formation of the PCG and PCT as well as the forces which acted against the development of collaboration. Second, I examine the literature on the factors that distinguish different approaches to collaboration, and which influence whether and how collaborations work.

I ask why and how collaboration and the new primary care organisations came to be seen as the answers to the problems of the NHS at this time. Statutory bodies were disjointed, primary care was highly fragmented and many health problems were multifaceted, complex and associated with social issues which extended beyond the traditional remit of the NHS. I argue that the *outer context* which acted to bring about a strong collaborative discourse and the introduction of PCGs and PCTs consisted largely in the role of the state which was changing in response to fragmentation and complex health and social problems. The perceived failure of hierarchies and the unacceptability of markets as mechanisms for co-ordinating healthcare delivery prompted government to aspire to a different form of governance: policy networks characterised by an enabling rather than coercing central government and relationships based on altruism, trust and reciprocity. I argue that the rhetoric of New Labour's "third way" resonated closely with policy networks as a form of governance, and examine the extent to which a paradigm shift from hierarchy to market to network actually accounts for New Labour's collaborative policies and interventions.

Finally I turn to the literature on collaboration and identify more proximal factors – the *inner context* - which may determine the effectiveness of PCGs' and PCTs' collaborative work. Individual factors, such as the role of the boundary-spanner, and organisational factors, such as the importance of trust and a shared vision and sense of purpose, are considered separately.

Chapter three explores the organisational forms of the PCG and PCT, the second element of the theoretical framework. I examine government policy and guidance documents in order to describe the 'generic' PCG and PCT, i.e. the structures and processes of these bodies as they were prescribed centrally and

which were common to all PCGs and PCTs. I also examine research evidence about the introduction of PCGs and PCTs and how they developed collaboration.

I describe three radical features of the generic PCG and PCT.

- First, this new model of primary care organisation provided a structure which had a locality-wide reach, and acted as an umbrella organisations for primary care in a locality.
- Second, professional clinicians occupied positions on the governing board, challenging the traditional manager-professional dichotomy.
- Third, a social services department (SSD) manager was to occupy a place on the governing board of an NHS body, a challenge to the established structural divides between health and social care organisations.

This chapter then describes the centrally prescribed processes through which PCGs' and PCTs' responsibilities to deliver primary care and to improve the health of their populations were to be met. These included

- clinical governance
- new budgetary arrangements
- the Health Improvement Plan (HImP).

Finally, on the basis of chapter two's analysis of the context in which PCGs and PCTs were introduced, and chapter three's assessment of their organisational forms and remits, I construct an analytical framework. Through this analytical framework, I identify four more specific research questions through which the main research questions are addressed:

RQ3: How far did the PCG's and PCT's organisational forms allow them to bring about a collaborative approach to improving the health of their population?

RQ4: How far did the PCG's and PCT's organisational forms equip them to develop a sense of corporacy and collaboration within the primary care community to develop and deliver primary care?

RQ5: Did the PCG and PCT's collaborative capacity manifest in collaborative processes and outcomes between primary care and other organisations at operational levels to promote independent living in older people and to tackle substance misuse?

Chapter four details how the study design, methodology and sample were intended to address the research questions. Inductive and deductive approaches were combined to test and develop theory in a longitudinal nested case study. Data were collected mainly through semi-structured interviews, which were supplemented by documentary and observational evidence. A framework (Ritchie & Spencer, 1994) approach to data analysis was used, assisted by NUD*IST computer software. The challenges of researching elite groups and of researching rapidly changing policy and implementation are documented. The limitations of the research methods are identified and discussed.

The findings from the case studies are presented in chapters five, six and seven which, between them, address the four specific research questions.

As chapter three set out, PCGs and PCTs were charged with improving the health of their population. **Chapter five** addresses RQ3, using the analytic framework set out in chapter three to examine whether and how four main features of Oxford City PCG's and PCT's organisational form equipped them with the collaborative capacity to advance a more public health-based approach to improving health. These features were common to both the PCG and the PCT but manifest differently in each. They were

- the locality-wide base of the primary care bodies
- their health improvement responsibilities
- the election of practising clinicians to their governing bodies
- the inclusion of an SSD representative on the governing bodies.

It draws on interview data to illuminate the experiences and perspectives of participants from different professional groups from the PCG and PCT and from the wider primary care community, as well as from participants whose main work lay outside the NHS. It also uses documentary and observational evidence.

PCGs and PCTs also had responsibility for developing and delivering primary care. They were expected to assure the quality as well as contain the cost of primary care services. **Chapter six** addresses RQ4, exploring Oxford City PCG's and PCT's capacity to bring together primary care workers to develop and deliver high quality primary care services and manage a budget for all

healthcare. The framework identified three features of the organisations' forms which were likely to facilitate this:

- the locality-wide base of the primary care bodies
- their budgetary and clinical governance responsibilities
- the election of practising clinicians to their governing bodies.

This chapter asks whether these features equipped them to bring about a more collaborative, corporate approach to the delivery and development of primary care in the city.

Chapter seven addresses RQs 5&6 examining how the two organisations facilitated collaboration locally at operational level through the two nested case studies: **tackling substance misuse** and **promoting independence in older people.** It explores the effects of organisational turbulence caused by the introduction of the PCG and the transition from PCG to PCT on collaborative working.

Chapter eight brings together the evidence and theory accumulated over the course of this study. It returns to the two main research questions and critically evaluates Oxford City PCG and PCT as mechanisms for collaboration by drawing together the key findings from the empirical research presented in chapters five, six and seven.

It then reconsiders and modifies the analytical framework in the light of the evaluations of the PCG and PCT, and relates the findings to debates in political science about the extent to which the third way can be thought of as a quasi-network mode of governance.

Finally, it considers the strengths and limitations of the study. In particular, I reflect on the design and methodology of the study, and consider the implications of carrying out research in such a rapidly changing policy environment.

Chapter two: Context for collaboration

2.1 Overview

In the late 1990s, collaboration became prominent in New Labour policies, and their predilection for it was manifest in their restructuring of the NHS, including the introduction of PCGs and PCTs.

Chapter one set out Sullivan and Skelcher's three-pronged framework for understanding collaborative mechanisms: examinations of the **context** in which collaboration operates, of the **organisational form** (structures and processes) of collaboration, and of the organisations' collaborative capacity and practice.

In this chapter I address the first of the three issues highlighted by this framework in relation to the PCG and PCT

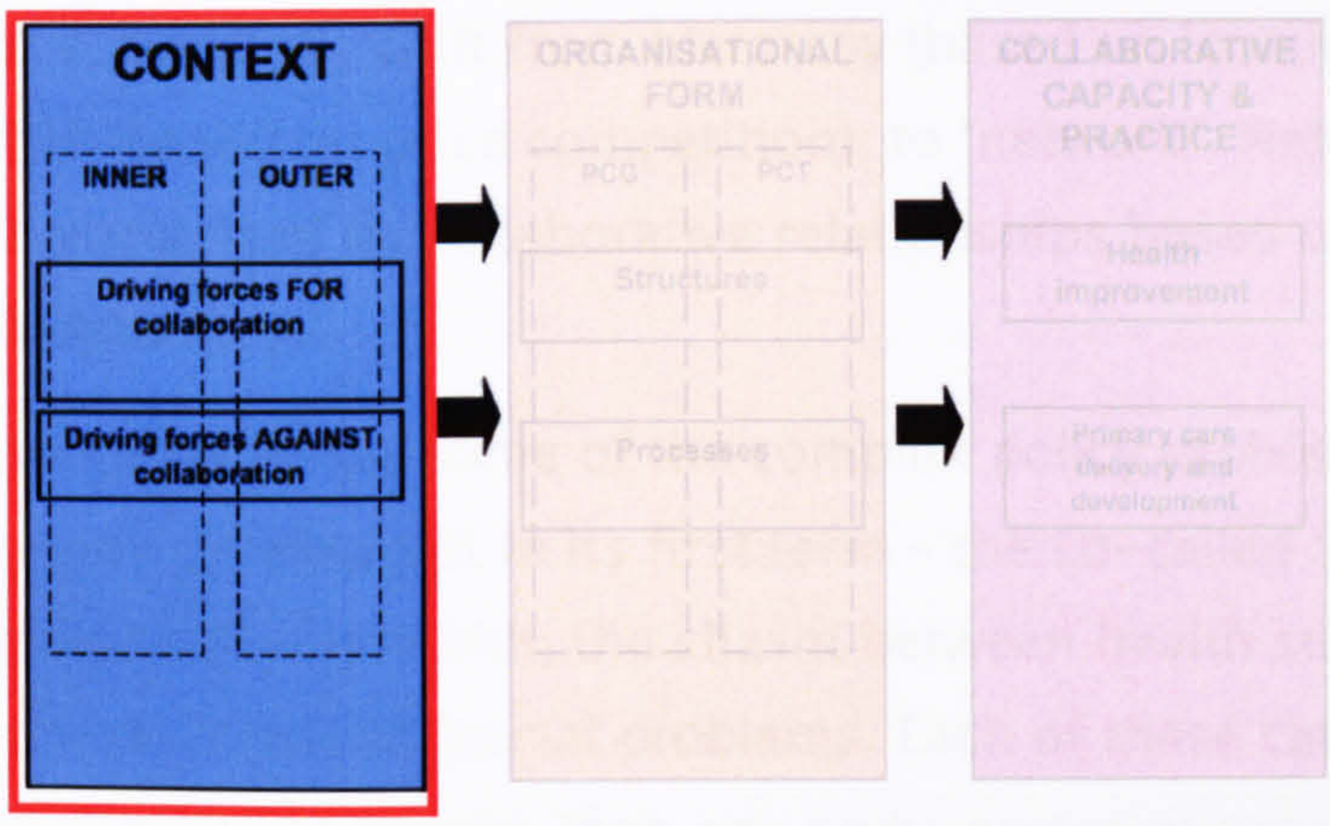

Figure 2: Realist theoretical framework - context

I ask two broad contextual questions. First, at the national level, what were the driving forces behind their introduction, their collaborative roles and responsibilities (outer context)? Second, given the variations in form and effectiveness of collaborative arrangements which come about as national policy is interpreted locally, what are the more proximal forces which can act locally to drive the development of a particular collaborative relationship, and to make it effective or not (inner context)?

The first of these two questions is answered by drawing on literature from political science to explore the context in which the concept of collaboration rose to such prominence in healthcare policy and practice and in which it came

to be seen as the answer to the problems of the NHS at this time. The second is addressed with reference to sociology and organisational science to identify the more proximal factors – organisational and individual – which combine to shape collaboration, or not, in a particular situation.

In **section 2.2** I argue that it is important to consider the context in which social policy operates. I distinguish the 'inner' context (relatively immediate factors which influence the local implementation of policy) from the 'outer' context (wider social, political, cultural, economic and historical factors). Understanding the driving forces behind collaboration in any given situation must take both into account. Sections 2.3 to 2.5 go on to address the outer context of this study, and 2.6 to 2.8 the inner context.

The strong collaborative discourse emerged largely from the historical and political context in which the New Labour government was elected in 1997. In **section 2.3** I examine this context in terms of the sequence of modes of governance – the mechanisms through which the state's responsibilities are met – since the inception of the NHS. This has been represented in the simplest terms as a paradigm shift from hierarchy (based on 'command and control'), to market (based on price competition), to 'network'. Networks, in this sense, are characterised by collaborative relationships based on trust, co-operation and voluntariness.

Section 2.4 begins by outlining some of the complex policy problems which faced the New Labour government in its first term – the so-called 'wicked issues' such as inequalities in health, the chasm between health services and social services, and multifaceted social problems. Each of these categories of problems called for input from more than one body, sector or organisation. A strongly collaborative discourse was attractive to this government as a pragmatic approach to dealing with the complexity of these wicked issues. The rhetoric of New Labour at the end of the 20th century came to resonate closely with policy networks. The notion of networks as a form of governance appeared to New Labour to offer a means of overcoming the limitations of what they characterised as hierarchies and markets, which led to fragmentation within the health service and had failed successfully to co-ordinate services in the public sector. Although they did not use the term 'network' itself, they made much of the contrast between the collaborative approach of the 'third way' and what they characterised as old Labour 'command and control' or Conservative 'markets'. Finally, I argue that it was politically expedient for the

government to distance itself politically from previous administrations' policies and ensure that its third way approach to governance was distinctly New Labour.

In **section 2.5** I critically appraise the representation of the changes in modes of governance as a sequence of three distinct steps from hierarchy to market to network. Although this representation has some heuristic value, it does not accurately or completely capture the context in which PCGs and PCTs were introduced. Exworthy et al (1999) argue that this assumption of paradigm shifts is over-simplistic: that since the inception of the NHS, hierarchy, market and network modes of governance have been impure, each co-existing alongside elements of the others. They propose that it is more appropriate to refer to periods of quasi-hierarchy, quasi-market and quasi-network. In this section I assert that governments' capacity to determine the mechanisms through which the state's responsibilities are met is limited by professional interests and autonomy, organisational and cultural differences and managerial-professional tensions. It argues that a more nuanced analysis is required which allows for the influence of culture, profession and status on all modes of governance.

New Labour's implicit claims of a network style of governance given the political and cultural realities of the public sector – particularly the NHS – at the beginning of the 21st century caused tensions, which I explore in **section 2.6.** Since hierarchies, markets and networks do not exist as pure forms of governance in a political world suffused with power differentials, political interests and professional autonomy, the adoption of a political philosophy based on such ideal types led to conflicts and tensions. It highlights some of the resulting tensions and contradictions, for example, between centralisation and devolution of power, between voluntary collaboration and attempts to enforce it, and between building long-term, trusting relationships and organisational turbulence.

Section 2.7 discusses the inner context – driving forces which act at a more local level. I distinguish individual and organisational factors, identified by organisational science and sociology, which drive or inhibit collaboration in a particular situation. These influence the implementation of national policy at local level and can determine whether or not a collaborative venture achieves what it set out to.

Section 2.8 explores two important features of the inner context in relation to collaboration. Investigation of these features requires the adoption of ethnomethodological and ethnological approaches. Both act primarily at the individual, rather than organisational level. First is the boundary-spanner, an individual with a multi-faceted role who develops complex perspectives on social problems and their solutions, initiates and maintains collaboration, and influences and motivates people over whom they have little control. Secondly the section examines the importance of trust in collaborative relationships.

In **section 2.9** I consider shared vision, clarity of purpose, ownership and accountability: features which are identified in the literature as key drivers of collaboration acting at an organisational level.

Finally, **section 2.10** summarises the argument of chapter two. I first set out the key aspects of the national driving forces behind the collaborative agenda of New Labour and the introduction of PCGs and PCTs. Second. I show that local factors also drive collaborative activity in particular directions.

2.2 Importance of understanding the context

Pettigrew et al (1992) make a forceful appeal for a "... contextual mode of research where the organisation is seen as embedded in its social, political and historical context." Various authors distinguish, implicitly or explicitly, two types of context: the domain or task environment (Thompson, 1967) and the general political, economic, sociological and technological environment (Jurkovich, 1974). Similarly, Pettigrew et al (1992) distinguish the inner from the outer context.

The inner context is made up of relatively immediate factors such as the local organisational landscape, including these organisations' ongoing strategy, structure, culture, human resources, management and political processes which influence organisational change and the local implementation of policy. The outer context encompasses the national political, economic and social circumstances in which policies are introduced as well as the "perception, action and interpretation of policies and events at national and regional levels... Social movements and long-term professionalisation or deprofessionalisation processes" (Pettigrew et al, 1992: 7).

Pettigrew et al argue that where context has been taken into account in research, it has tended to be too heavily reliant on explanations relating to the inner context, thus neglecting factors in the outer context. They argue that the general lack of attention to political, cultural and historical context has led to a distorted or impoverished analysis of the process of change:

> Where the change project is treated as the unit of analysis the focus is often on a single event or a set of discrete episodes somehow separate from the immediate and more distant antecedents that give those events form, meaning and substance. (Pettigrew et al, 1992, p6)

Given the organisationally and politically turbulent history of the NHS, the effects of its past in determining its future development should not be underestimated (Lawrence, 1984; Zald, 1987; Selznick, 1957; Stichcombe, 1965). Public sector organisations in particular, operating as they do in highly politicised realms in which professionals closely guard their power and social positions, are not amenable to analyses which are limited to formal, rational problem-solving and implementation (Pettigrew et al, 1992). They warn that explanations for change or lack of change will often be couched in terms of rational, incremental processes of organisational change, and call for an approach which takes into account political factors, considerations of power and vested interest, as well as less predictable factors.

The relationship between context and organisational change operates in both directions: not only does the context shape collaboration, the collaboration also shapes the context. As Ling (2000, p85) notes, "Partnerships do not exist in a vacuum. They emerge from an existing institutional architecture. Some may reinforce and strengthen this architecture while others may undermine and challenge it."

2.3 Outer context: changing role of the state

The following sections (2.3 - 2.6) address the outer context in which New Labour was elected and introduced its collaborative policies. This section examines modes of governance, or the mechanisms through which the state's responsibilities are met.

Political science points to the changing role of the state, the mechanisms through which it ensures it meets its responsibilities, and the relationships

between it and its institutions and agents, as significant in understanding the rise of collaboration in public policy. Sullivan and Skelcher (2002), for example, describe the development of the collaborative agenda in the context of the changing institutional structure of the public sector and the emergence of new philosophies of public management and governance. They chronicle the progression of the role of the state in Britain from the 1970s to the present day in terms of three phases: *overload, hollowing out* and *congestion.* The shift over time in the co-ordination of governance is alternatively presented in terms of a progression through hierarchies and markets to a networked mode of governance (Thompson et al, 1991; Rhodes, 1997; Stoker, 1997, 2000; Clarke & Glendinning, 2002; Powell & Exworthy, 2002). The two accounts of change use different terminology to describe corresponding periods of government.

2.3.1 Hierarchy

A hierarchical mode of governance is characterised by highly centralised policy-making and resource allocation, with limited autonomy at the periphery and an effective transmission belt implementing central directions (Exworthy et al, 1999). Under it, government departments are organised *hierarchically* in silos, often with a strong professional orientation, each with a particular approach to the way problems are defined and solutions prescribed (Hudson, 1987). The NHS from its inception in 1948 to the election of a Conservative government in 1979 is generally considered to have been hierarchical and bureaucratic (Harrison, 1993) with central government making policies at a national level then exerting strong control over their transmission to the periphery (Saltman & Von Otter,1992).

King (1975) describes the Labour government of the 1970s as *overloaded* with responsibilities. The underlying design principles of this overloaded welfare state were its large welfare bureaucracies, professional rather than managerial control, reliance on representative forms of democracy and the notion of a passive community (Sullivan & Skelcher, 2002:16). Authority for jurisdictional responsibilities, which would sometimes overlap, was divided between separate government empires, unable to implement policy and losing legitimacy.

Both of these accounts underline the bureaucratic character of the NHS in its first three decades, although where a hierarchical model assumes that central

government controls the bureaucracy, the notion of the overloaded state allows that professionals held considerable power.

2.3.2 Markets

The Conservative government's response to the overloaded hierarchical state was major restructuring of the public sector, and what has been described as the injection of market mechanisms to the NHS (Walshe, 1995; Salter, 1998, in Exworthy et al, 1999). Most commentators point to the purchaser-provider split as the most important aspect of marketisation in this period (Exworthy et al, 1999).

Sullivan and Skelcher term this phase *hollowing-out*, one aspect of which was the new public management of the 1980s. At the heart of new public management was a set of beliefs that government should be smaller, more concerned with identifying what services needed to be provided and less with delivering them itself, and that market forces had a key role to play in this respect. It was argued that exposing people in the public sector to market forces would improve the economy and efficiency of activities and, if markets could be created in which users had choices, increase the responsiveness and consumer-orientation of services. This analysis chimed with the emerging political dominance of the New Right (Sullivan and Skelcher, 2002).

During the process of hollowing out, the activities of the state were slimmed-down, leaving it with the policy-making functions of the core executive, regulatory functions for contracted and privatised services, and the oversight of residual direct provision functions. It meant that the role of service commissioning and purchasing was separated from that of provider, and that authority within state bureaucracies was decentralised to manage these new relationships. These complex relationships and contractual arrangements, often overseen by appointed boards, resulted in diminished transparency. In the 1990s, these so-called markets emphasized competition and the exercise of purchasing leverage rather than collaboration, and led to increased fragmentation (Wistow & Hardy, 1996). This meant that local authorities had to deal with a potentially large number of primary care purchasers and service commissioners (Glendinning et al, 2003). Hollowing out "....produces an environment of organisational and political fragmentation in which the old certainties about the location of responsibility, accountability and authority for public action are lost." (Sullivan and Skelcher, 2002: 18)

2.3.3 Networks

The introduction of market forces to the public sector, and the attendant division of organisational responsibilities and authority, acted to stimulate the collaborative agenda. The hollowing out of large welfare bureaucracies generated a need for the "...application of significant resources to negotiate the development and delivery of public programmes" (Skelcher, 2000: 12). From here, a new phase, that of the *congested* state, was entered. This was characterised by *network* modes of governance.

The focus of policy networks theory is the manner in which the steering and regulation of societies takes place given the multiplicity of organisational actors, highly differentiated policy sectors and absence of centralised authority. It is used to analyse the structure of governance: the pattern of interorganisational relationships as a whole, the linkages, their intensity and standardisation. From this perspective, the policy network comprises:

> ...all actors involved in the formulation and implementation of policy in a policy sector. They are characterised by predominantly *informal* interactions between *public and private* actors with distinctive, but *interdependent interests* who strive to solve problems of collective action on a central, *non-hierarchical* level. (Borzel, 1998: 20; italics in original)

The network mode of governance:

> ...arises from a view that actors are able to identify complementary interests. The development of interdependent relationships based on trust, loyalty and reciprocity enables collaborative activity to be developed and maintained. Being voluntary, networks maintain the loyalty of members over the longer term (Lowndes and Skelcher, 1998: 319-20).

> If it is price competition that is the central co-ordinating mechanism of the market and administrative orders that of hierarchies, then it is trust and co-operation that centrally articulates networks (Thompson et al, 1991: 15).

Network governance has been characterised as a move away from the old left statism and the new right markets (Clarke & Glendinning, 2002). Rummery & Coleman (2003:1773) locate the emergence of a networked mode of

governance in "...a loosening of statist, bureaucratic forms of welfare delivery and a simultaneous recognition of the failure of markets... to provide an acceptable alternative in welfare delivery".

2.4 Outer context: wicked issues and the third way

2.4.1 Wicked issues

When the new Labour government was elected, it inherited a number of what were termed 'wicked issues' because they "...defy efforts to delineate their boundaries and to identify their causes, and thus to expose their problematic nature" (Rittel and Weber, 1973: 167). These policy problems were attributed to deeply embedded problems such as longstanding cultural, sectoral and organisational divides, complex interactions between social, economic, environmental factors, and the fragmentation of the NHS due to GP fundholding (GPFH) and the internal market. They required collaboration not only between NHS bodies and organisations outside of the NHS, but also within primary care and between primary care and other NHS bodies.

These wicked issues took various forms, but three broad categories may be discerned: health inequalities, the chasm between the NHS and social services departments, and complex social problems such as social exclusion and crime.

Inequalities in health

Health improvement and the reduction of inequalities in health was one of the most prominent themes in the 1997 white paper *The New NHS: Modern, Dependable* (Secretary of State for Health 1997; Klein, 2001). 'Health improvement' has a variety of meanings, which can be distinguished according to the degree to which NHS activity is seen as central (Abbot & Gillam, 2000) and distinct from developing primary care and community care and commissioning hospital services. It includes health promoting activities which take place outside the NHS (for example in schools and workplaces) and efforts to address the broader social, economic and environmental factors which contribute to health such as social exclusion, pollution, transport, housing and poverty (Gillam et al, 2001). The NHS itself did not have the necessary resources to improve health and reduce health inequalities alone; it had to become a partner in a wider social engineering project (Klein, 2001).

The government's commitment to raising the profile of public health was further demonstrated in the publication of the consultative green paper *Our Healthier Nation: A Contract for Health* (Secretary of State for Health, 1998) and the white paper *Saving Lives* (Secretary of State for Health, 1999), as well as in commissioning of the Acheson Inquiry into Inequalities in Health (Acheson, 1998) and its response (DH, 1999) in which it broadly accepted the Inquiry's analysis and recommendations, only three out of 39 of which focussed specifically on the NHS (Evans, 2004). The government acknowledged the complexity of the challenge of reducing inequalities and the wide influences on health status, the solutions to which lay far beyond the scope of the NHS. It signalled an approach which would require collaboration between a range of agencies, government departments and sectors.

Health-social services divide

A second problem was the so-called 'Berlin Wall' (Hudson, 1999a) between health and social services. The health and social care boundary is organisational, functional, professional and political, and has been on the political and professional agenda for some time. These structural service boundaries are built into the architecture of the post-war welfare state. They were created and are reinforced by organisational structures and by different modes of governance and accountability. Collaboration between health and social care therefore requires negotiation of a number of sensitive issues (Sullivan & Skelcher, 2002). Tensions between medical and social models of care are reflected in different organisational cultures and modes of working (Hudson, 1987). The NHS is hierarchical, and the local delivery of services is ultimately accountable through a management structure to the Secretary of State for Health, while social services departments are accountable, through elected councillors, to the electorate (Sullivan & Skelcher, 2002).

A failure of co-ordination of health and social services affects some groups disproportionately. An important example is older people, for whom the failure of co-ordination of health and social services can lead to gaps in services and undermine independence (O'Hagan, 1999)[1]. The outcomes of such failures

---

[1] See chapter seven, where a nested case study of the health improvement priority to promote independent living in older people is reported

were clearly manifest in situations such as the vicious cycle of 'bed-blocking' (Audit Commission, 2000a), the occupation of beds on acute hospital wards by (usually elderly) patients due to a lack of social care services to facilitate their discharge although they no longer required a high level of intervention. Rising hospital admissions and falling lengths of stay meant reduced rehabilitation, placing greater demands on social services which absorbed funds which were consequently unavailable to be spent on preventive services in the community to help contain the rising hospital admissions. This failure to invest in low-level, preventive services meant the overuse of acute and residential care. Co-ordination failure also meant costly duplication of assessments and services (DH, 2000; Rummery & Coleman, 2003). There was growing recognition on both sides of the NHS-social services divide of their interdependence in order to address such failures of service co-ordination.

The commitment to reducing waiting lists required the prevention of unnecessary hospital admissions and prompt discharge of people who did not need medical care. This depended on adequate funding in social services and also partnership with housing and other local authority departments and the non-statutory sector to promote independent living and prevent ill health.

Various items of legislation and policy recognised the need for greater collaboration and were put in place in an effort to remedy these problems. The 1999 Health Act flexibilities, for example, allowed health and local authority organisations to pool budgets, delegate commissioning responsibilities to a single 'lead' organization and integrate front-line health and social services staff in one organization.

National Service Frameworks (NSFs) set minimum standards for delivery and monitoring in particular areas of care. The NSF for Older People (DH, 2001) was a service level model which set standards for the delivery and monitoring of health services for older people and emphasised collaboration between NHS services and local authorities in improving services for older people (Glendinning et al, 2001).

Complex health and social problems

Many challenges facing communities, countries and governments are sufficiently complex in scope and scale as to require the involvement of a range of actors with complementary perspectives, expertise and resources (Sullivan & Skelcher, 2002). As the report of the Acheson Inquiry into

inequalities in health found, health in its broadest sense is influenced by environmental, social, economic and other factors. Such complex health and social problems manifest in a wide variety of ways, including the problems associated with substance misuse.

The prevalence of substance misuse increased dramatically through the 1990s and the social and health-related problems associated with it nudged their way up the political agenda[2]. The multi-faceted nature of these problems meant the solutions required to tackle them were wide ranging – from health, crime, prevention, education – and required input from a correspondingly diverse range of services and agencies. Early in its first term, the New Labour government announced a ten-year drugs strategy: *1998-2008: Tackling Drugs Together to Build a Better Britain* (Home Office, 1998). *Models of Care*, a *de facto* National Service Framework for drug treatment, was published in 2002 by the National Treatment Agency for Substance Misuse, a special health authority created by the Government in 2001 whose aim was to improve the availability, capacity and effectiveness of treatment for drug misuse in England.

2.4.2 Political pragmatism

As well as the policy problems such as the three above which drove the renewed rhetoric of collaboration, there were political reasons for ratcheting-up the collaborative discourse. Klein's (2001) analysis locates its origins in New Labour's determination to distinguish itself from previous administrations, including 'old Labour' whose appeals to working class solidarity were no longer electorally viable in the socio-economic climate of the late 20th century, characterised by globalisation, the decline of industry, and dominated by consumer, rather than producer, politics.

The *NHS Plan* set out the government's policy for continuing NHS reforms. It heralded changes which would distance New Labour's approach from those of previous administrations:

> Until the 1990s the NHS was run hierarchically with little room for local innovation or independence. In the 1990s the internal market

---

[2] See chapter seven, where a nested case study of the health improvement priority to tackle substance misuse is reported

> introduced competition but failed to bring improvements. A new model is needed. (Secretary of State for Health, 2000: 30)

New Labour's pragmatics in government became known as the 'third way'.

2.4.3 Third Way

New Labour's modernisation project, termed the 'third way', was pragmatically, rather than ideologically, driven. It was closely associated with the work of the sociologist, Giddens (1998), who argued that the distinctions between left and right were unhelpful in addressing contemporary problems. It claimed to do away with allegedly outdated notions of ideological purity, and to move "beyond left and right" to a political philosophy embodied by the phrase "what counts is what works" (Labour Party Manifesto, General Election 1997; Bond and Le Grand, 2003). Third way rhetoric was peppered with references to collaboration and partnership and, through it, New Labour sought to reconcile previously antagonistic forces such as social justice and a strong economy (Klein, 2001).

The collaborative rhetoric of the third way can be seen as both a pragmatic response to the 'wicked issues' they faced in government, and also a political manoeuvre which aimed to distance New Labour from the perceived failure of governance based on hierarchy or market forces successfully to overcome them. The infusion of the third way to health policy can be felt strongly in the White Paper, *The New NHS: Modern, Dependable* (Secretary of State for Health, 1997) which presented an approach to the problems of providing and co-ordinating health care and improving health in which trust, partnership and collaboration were strong themes.

The resemblance between the new government's third way, with its adopted terminology of collaboration, and the defining characteristics of a network mode of governance was strong. It was reflected in the government's many references to the key characteristics of networks such as altruism, trust, co-operation, collaboration, partnership, alliances, and inter-agency work, even though politicians rarely used the term 'network' itself (Exworthy et al, 1999). Collaboration exemplified New Labour's 'pragmatic modernisation' (Clarke & Glendinning, 2002: 33), and the policy network, characterised by an enabling, rather than a coercing, central government (Newman, 2001), embodied the pragmatic 'between and beyond' spirit of its third way (Clarke & Glendinning, 2002).

2.5 Outer context: cultural and political complexity

The proposition that a sequence can be traced from hierarchy to market and then to a network mode of governance has some substance, credibility and theoretical value. And, politically, it suited New Labour to present it that way. However, it does not account fully for the history of the emergence of the 'third way,' and even as a partial explanation, it is not uncontested. The sequence is challenged by Exworthy et al (1999) on the grounds that these ideal types fail to recognise the political and organisational complexities of the NHS. They argue that it overlooks the differences in power, culture and accountability between different professions and between professionals and managers. Elements of hierarchy, market and network were all evident in each of the three phases and the terms quasi-hierarchy, quasi-market and quasi-network are more appropriate.

2.5.1 Quasi-hierarchy

Exworthy et al (1999) argue that the NHS was never a pure command-and-control hierarchy: prior to the 1974 reorganisation, there was a deficient transmission belt between centre and periphery. Central government had considerable formal responsibility with little authority.

Hierarchies, planning and strategy were established in the period which followed the 1974 NHS reorganisation, with the introduction of Health Authorities. However, the so-called hierarchy was limited by the autonomy afforded to professionals. GPs, in particular, resisted becoming a part of a hierarchically managed NHS by fighting to retain their independent contractor status. As Klein (1995) put it, the politicians set the size of the budgets, but the doctors controlled how they were spent.

Rhodes (1997) argues that *professionalized* policy networks were a strong feature of the NHS during the so-called hierarchical period. These professionalized networks consisted of medical professionals demonstrating a high degree of independence and a high degree of insulation from other networks or interests. These contrast with third way networks which purport to be more inclusive and embrace private, voluntary and informal links (Exworthy et al, 1999).

2.5.2 Quasi-market

Neither was the NHS ever fully marketised, partly because it was considered politically impossible to allow market mechanisms to have full rein (Klein, 1998). Rather, it became a quasi-market which exhibited a mix of private sector ideas and practices with public sector funding and regulation (Exworthy et al, 1999). In some areas, GPs chose to enter into this quasi-marketplace by becoming GP fundholders, a system introduced to promote better value for money and to improve consumer choice. Practices, or groups of practices could opt to hold a budget to pay for specific hospital care, drugs, staffing in the practice and community services. Various collective commissioning arrangements emerged whereby groups of practices purchased together, allowing economy of scale in commissioning. Practices could also opt for total purchasing, in which practices could buy any type of NHS care (Dixon & Glennerster, 1995).

Further, community health services, in place during the so-called market period, were said to exhibit many of the attributes characteristic of network structures (Flynn et al, 1996). They represented networks of intersecting interests, through which information about the quality of services was transmitted informally. These networks became essential sources of information on which purchasers could base transactions in the quasi-market.

2.5.3 Quasi-network

While New Labour was liberal in its use of collaborative rhetoric in ways which resonated with policy networks, there were also strong indications that elements of market and hierarchy were to continue. In 1997 the *New NHS* claimed to reject both "...the old centralised command and control systems of the 1970s" and the "...divisive internal market system of the 1990s" (Secretary of State for Health, 1997: 10), yet by 2000 New Labour's NHS contained substantial elements of both. The contradictions which arose are highlighted by Dowling & Glendinning (2003). The *NHS Plan* stated that the "NHS cannot be run from Whitehall... Clinicians and managers want the freedom to run local services around patients' needs" but also that "...standards cannot simply be set locally... Inspection, incentives, information and intervention, operating under the umbrella of clear national standards, will help reshape services around the patient" (Secretary of State for Health, 2000: 30). PCGs and PCTs were required to be involved in the creation and strengthening of devolved,

local organisational and service networks, as well as more directive, hierarchical forms of steering (Glendinning et al, 2003)

2.5.4 Interprofessional and professional-managerial tensions

The ideal types of hierarchy, market and network cannot be applied strictly to governance in the NHS partly because of the historical and political forces which shaped the NHS, particularly the struggles between managerialism and professionalism within it, and also the interprofessional tribalism arising from differentials of power and status between professions.

Managerialism and professionalism

The manager-professional distinction has been the subject of a considerable literature, characterised by Exworthy & Halford (1999) as a 'pastiche of popular and academic images.' In this, the stereotypical manager is committed to running bureaucracies, to establishing and applying rules, and depends on his or her position in the bureaucratic hierarchy and on their knowledge of organisational politics and practice, acquired through experience in a particular organisation. He or she is seen to be conformist, self-interested and career motivated. Professionals, in contrast, are committed to the provision of expert services and advice, depend for their power and authority on specialist knowledge which supersedes the confines of any single organisation, and are creative, altruistic and driven by ethical commitment to their expertise. The professional autonomy of medicine has been highly prized, particularly in primary care where GPs have held onto their status as independent contractors and have not become employees. GPs have generally held to a medically-oriented approach to the health of individuals compared to some other members of a primary health care team (PHCT), such as district nurses (although many GPs consider themselves to be less medically- and individually-oriented than specialist clinicians).

Differences between the two groups are problematic for hierarchies and networks. A hierarchical system depends on management structures which ensure local implementation of central government policy, but the tensions arising from their different motivations mean professionals may resist implementing policy as dictated by managers. They also present challenges to networks, since trust and reciprocity are not easily built between groups or individuals with different values.

Professional and managerial roles have been blurred. Managerial-professionals, evident in the acute sector in the form of, for example, medical directors, were viewed by some as not simply an effort to control professionals, but as an opportunity for new patterns of compromise between managerialism and professionalism (Harrison and Pollit, 1994). Hoggett identified the conversion of professionals into managers as a distinctive feature of change in the early 1990s:

> Rather than attempt to strengthen 'management' in order to control professionals, the strategy shifts towards creating managers out of professionals. A new generation of unit managers begins to emerge who combine technical expertise with managerial competence (Hoggett, 1991: 254).

This professional-managerialism did not emerge in primary care beyond the introduction by the Conservative government in the 1990s of GP fundholding and associated primary care commissioning models, a scheme under which GPs took on a limited managerial role for their own spending or that of a group. There was no precedent for compulsory managerialism for GPs at a local level. As I will elaborate in chapter three, the PCG and PCT model challenged the manager-professional distinction through the position of GPs and community nurses on their governing bodies, with strategic responsibilities at a local level.

Interprofessional divides and tribalism

Organisational culture consists of informal networks of co-operation and conflict, created and sustained by collective norms and values of its members and individuals' actions and beliefs (Mackian, 2002). Organisational and cultural chasms existed between professional groups, presenting difficulties for all modes of governance, not least networks. The role of culture is often seen as central to the development of collaborative capacity within organisations and across sectors (Newman, 1994). Hiscock & Pearson (1999, cited in Mackian, 2002: 215) warn that collaboration can be hindered by a lack of understanding of organisational cultures. According to McGann and Gray (1986), in order to develop the cultural awareness required for collaboration, there must be a widespread understanding of the concerns of particular actors combined with the appropriate leadership and strategic intervention in order to

secure the required culture and organisational ownership of collaboration as a way of working.

Traditionally, organisations within primary care (mainly general practice) had tended to operate in isolation from others and had little history of collaboration: the primary care of the 1990s was characterised by the development of services in isolation and a culture of competition brought about by quasi-internal market forces in the health system. The vision for the 'new' NHS was for a more integrated primary care community at local level which would work together to deliver and develop primary care for its population. It would also work more closely with social care, which it had not done historically.

According to Hudson's (1999) analysis, policy on collaboration (in this case, the relationships between health and social services) was based on a hugely optimistic model for most of the post-war period. When central governments' approach of pointing out the benefits of collaboration and exhorting agencies to work together had been unsuccessful, they had clung to an optimistic perspective on collaboration which assumed that organisations simply lacked the technical know-how to collaborate, so responded by issuing instructions on how to do it better. This approach failed to take into account the cultural differences between professions within primary care and between them and social services.

Under New Labour, efforts were made to lessen the structural differences in accountability and management hierarchies between NHS and SSDs through the 1999 Health Act flexibilities. While New Labour's early white papers and legislation focussed on structural change, the Modernisation Agency was tasked with promoting cultural change (STBOP, DH, 2001), and Local Strategic Plan (LSP) development was to focus on partners' capacity to work together more effectively (DETR, 2001). However, a "legacy of interorganisational divides" remained (Rummery & Coleman, 2003: 1773), and they have been complemented by interprofessional boundaries between social workers, doctors and nurses, characterised as professional tribalism (Dalley, 1989).

On managing organisational cultures, Pettigrew observes that the values of established and defensive professional groups are deeply rooted, shaped by socialisation processes outside the control of managers, and likely to survive attempts at top-down restructuring, even if driven underground. Whether

culture can, in reality, be managed is doubtful, but it should at least be considered when advocating changes that may challenge them (Hatch, 1997).

Hudson takes New Labour's approach to collaboration – the removal of constraints, introduction of incentives and closer monitoring – to indicate the adoption of a more realistic perspective. Exhortations to agencies to be decent about joint working have been replaced by a panoply of sanctions, incentives and threats (Hudson, 1999a, in Powell & Glendinning, 2002: 9).

To summarise, an analysis of the role of the state which describes a sequence from hierarchy, to market, to network is oversimplified and does not account for the effects of important contextual factors which lead to the impurity of, and overlap between, these forms of governance. An analysis of PCG's and PCT's collaborative endeavours must take into consideration such complexities as the professional autonomy of doctors and the independent contractor status of GPs (Klein, 2001); the presence of attributes characteristic of network structures during the hierarchy and market modes of governance (Flynn et al, 1996); interorganisational divides (Rummery & Coleman, 2003); and interprofessional boundaries or professional tribalism (Dalley, 1989) between social workers, nurses and doctors.

A government's capacity to determine the mechanisms through which the state's responsibilities are met is limited by professional interests and autonomy, cultural differences and managerial-professional tensions. More nuanced policy making is required which allows for the influence of culture, profession and power on all modes of governance. As will be seen in chapter three, New Labour was sensitive to these issues to some extent in its plans for the introduction of PCGs and PCTs.

2.6 Outer context: tensions in the third way

Political scientists' characterisation of the role of the state under previous administrations as hierarchies and markets, and of the position of the third way, were over-simplified. Over time, certain contradictions became apparent in New Labour's approach to organising the NHS. There were tensions between, on the one hand, a rhetoric which suggested collaboration based on voluntarism, trust, reciprocity and loyalty and devolution of power to managers and practitioners locally and, on the other hand, a reality which saw an increase in national targets, monitoring and central control. A further tension

was that between the exhortations to build collaborative relationships and the turbulence caused by fast-paced modernisation, restructuring and organisational change.

2.6.1 Statutory voluntarism

Powell et al (2001) questioned whether partnerships can be enforced by statute, and doubted that successful partnerships would result simply because stakeholders are told to work together. Benson (1975) warns that the nature of authority and resource relationships between organisations can become imbalanced when a superordinate body such as a government legislates that organisations should work together to maximise efficiency and effectiveness, when agreement amongst participating organisations about their roles and scope is low. In the search for scarce resources such as authority and money, organisations may enter into imposed rather than voluntary collaborations for which they are not fully equipped.

To many, the strengthening of central control through performance management and targets sat uncomfortably with the collaborative discourse of trust, participation and inclusion (Newman, 2000). The trust-based relationships were at risk of being undermined by heavy-handed regulation and performance management, under which each organisation tries to meet separate targets.

This central control extended to imposing a 'duty' to co-operate, as the *NHS Plan* (Secretary of State for Health, 2000) warned that action would be taken against ineffective health and social care partnerships, and they would be compelled to use the new Health Act flexibilities. Powell et al (2001) conclude that neither the sanctions nor incentives within the *NHS Plan* were sufficiently strong to elevate partnerships towards the top of the policy agenda. *Statutory voluntarism* is the term coined by Paton (1999: 69) to describe the top-down pressure, even sometimes coercion, to work in partnership. Notwithstanding the strengths of sanctions and incentives, statutory voluntarism appears at odds with how sustained partnership activity is seen to exist in the voluntary co-operation of individuals for the common good (Baum, 1999 and Champlin, 1999).

Decentralisation must be balanced with accountability and the plethora of initiatives, targets – and the PCG and PCT themselves – did not evolve in an

organic, spontaneous way. The question is not "was the collaboration entirely voluntary" but "was the balance between voluntariness and accountability right and consistent with the rhetoric of networks, and was it effective for collaboration?"

There is potentially a tension between such hierarchical modes of policy implementation and the local ownership and commitment likely to sustain local collaboration. Priorities set out in the *NHS Plan* and NSFs drove much of the organisations' work and suggested a hierarchical rather than network approach to collaboration. External pressure to work in partnership can undermine trust in collaborations (Rummery, 2002). Glendinning et al (2003) note that many areas of collaborative activity were determined primarily by national priorities such as NSFs (DH, 1999g, 2000a, 2001b) and the *NHS Plan* (Secretary of state for Health, 2000). The national priorities which drove the work of PCG/Ts and some of their collaborative partners frequently diverted attention from external collaborative relationships and sometimes undermined them (Glendinning et al, 2003). Indeed, separate performance management systems emerged for PCGs and local authorities.

Wide acceptance of partnerships to reduce health inequalities was found to be impeded by the stick of vertical performance management by Powell et al (2001). Powell and Glendinning (2002: 6) argue that enforced partnerships "may be incompatible with the whole notion of partnership, which is implicitly associated with some degree of choice and autonomous action." Trust, in particular, may be jeopardised in such circumstances (Rummery, 2002). The sanctions and incentives in the *NHS Plan* (Secretary of State for Health, 2000)appeared to be a case of overt steering rather than the hands-off enabling which would characterise a networked governance of welfare (Johansson & Borell, 1999; Rhodes, 1997, cited in Rummery & Coleman, 2003).

2.6.2 Decentralisation

The New Labour government's talk of a decentralised NHS was consistent with a network mode of governance. A decentralised public service is one in which significant decision-making is made by operational level managers and staff who are closer to the people receiving services. When responsibility for budgetary control is held at this level, services can be more responsive to need (Pollitt and Harrison, 1992). Decentralisation was a theme of *The New NHS,* which claimed that, "For the first time in the history of the NHS all the primary

care professionals, who do the majority of the prescribing, treating and referring, will have control over how resources are best used to benefit patients" (Secretary of State for Health, 1997, p37).

The white paper *Shifting the Balance of Power within the NHS* claimed responsibility would be devolved from Whitehall to those closer to the delivery of services: "Because we trust people on the frontline, the centre will do only what it needs to do; then there will be maximum devolution of power to local doctors and health professionals" (DH 2000, p57). Central government's intentions to "devolve decisions to frontline staff" (p9) and "to reduce hierarchies and develop self-managed teams" (p25) was reiterated in *Delivering the NHS Plan* (Secretary of State for Health, 2002). Indeed, it announced that Health Authorities, which had supported PCGs and manage the performance of PCTs, were to be abolished in April 2002 and many of their responsibilities, and 75% of the NHS budget would be devolved to PCGs and PCTs. Strategic Health Authorities were established with responsibility to performance manage all local NHS organisations (Glendinning & Dowling, 2003).

Decentred governance must, of course, strike a balance between on the one hand devolution and participation and on the other, central control and formal accountability (Bevir & Rhodes, 2001). However, Deeming (2004) asserts that most health policy analysts consider the NHS under New Labour to be over-centralised. While making the case for devolution, New Labour simultaneously imposed a high level of central direction over the NHS.

Clarence and Painter (1998: 15), for example, argue that New Labour's collaborative discourse was countered by a conflicting and contradictory discourse of centralisation and demands for performance. Bond & Le Grand (2003) question whether local responsibility is compatible with the development of national standards and regulatory bodies. The *NHS Plan* (Secretary of State for Health, 2002) set out extensive plans for performance monitoring, audit and management that would be applied to the NHS, including primary care (Glendinning & Dowling, 2003).

Two national bodies were set up to support the new managerial accountability, and the benchmarking and performance management system within the new NHS (Rouse & Smith, 2002). The National Institute for Clinical Excellence (NICE) would tackle widespread and unpopular variations in health services by setting standards and benchmarks, and the Commission for Health Improvement

(CHI), later to become the Healthcare Commission, would inspect services to ensure the targets in the *NHS Plan* were met. National Service Frameworks (NSFs) and clinical governance were also introduced. Clinical governance was the system through which the quality health services was to be monitored, safeguarded and improved (see 3.5). Together with the *NHS Plan*, a performance rating system for health services, NICE, CHI and NSFs formed a strong performance management framework.

2.6.3 Organisational change and transition processes

In the years following the election of the New Labour government, the pace of change in the structures, directives and relationships within the NHS and local government was tremendous. As this chapter has shown, the context in which PCGs and PCTs were introduced was fast-moving and challenging on many fronts.

The New NHS: Modern, Dependable (Secretary of State for Health, 1997) appeared to acknowledge the potential cost of ongoing reorganisations in terms of staff capacity and morale and pledged to minimise upheaval.

> This White Paper marks a watershed for the NHS... But it will not mean a wholesale structural upheaval, generating costs and disruption that get in the way of patient care. The NHS has had all too much of that. There is no appetite amongst patients or staff for such an upheaval. But there is an appetite for change that goes with the grain of the NHS and its traditional values. (Secretary of State for Health, 1997: para 10.1)

These promises echoed hollow in the ensuing raft of policy and legislation. The costs of this organisational turbulence were found to be considerable. The development and maintenance of collaboration with external organisations is liable to be impeded by organisational change (Regen et al, 1999). It may disrupt relationships between key individuals in collaboration, and can encourage organisations to be inward- rather than outward-looking. New targets and directives may divert attention from, and even undermine, external collaborative relationships (Glendinning et al, 2003).

The swift transition from PCG to PCT allowed insufficient time for PCGs to progress through their stages of development to maturity. To some extent they came to be regarded as transitional organisational forms rather than

organisations in their own right. Rummery & Coleman (2003) found that clarity and realism of purpose, commitment to and ownership of partnership, had been particularly affected by the organisational instability experienced by the PCGs in their study, as had the establishment of clear and robust joint commissioning structures. Hunter (2003) attributed the limits in the effectiveness of HImPs to the lack of time for adequate consultation and involvement processes during their production, and the lack of time to mature before they transmogrified to HIMPs.

Paradoxically, change, which is implicit in almost all interagency working, is easier to bed down where there is continuity of personnel in key management positions (Pettigrew et al, 1992) a situation that is difficult to achieve in the prevailing climate of organisational turbulence (Sullivan & Skelcher 2002).

However, as Bond and Le Grand (2003) argue, one feature of the PCG and PCT mitigated the effects of organisational change. GPs are more embedded in their communities than are managers so their occupation of key roles in PCG/T was advantageous – as the others came and went, they often provided continuity.

2.7 Inner context: local driving forces

The first part of this chapter presented an account of the national political and historical context in which PCGs and PCTs were introduced, but more proximal factors also bear on the effectiveness of collaborative relationships. Evidence from Forsgarde et al (2000) and Withington & Giler (2001) suggests that interprofessional barriers are not overcome by creating 'joint' organisations. Mackian (2002: 212) identifies a disjuncture between policy environments and structures which theoretically enable positive change, and on-the-ground realities of implementation within complex social and cultural settings. The remainder of this chapter (2.7 to 2.9) turns to the 'inner context,' the locally variable factors identified by organisational science and sociology, wherein other driving forces for collaboration lie.

Studies of collaborative practice refer to local *organisational* success factors as well as key *individuals* who bring particular skills and play particular roles in the collaborative effort (Friend et al, 1974). According to Poxton,

> a new policy environment and new organizational arrangements should make co-operation and collaboration easier than it has been in the past. But real success will depend on the determination and creativity of practitioners and managers as it will on Government edict and structural change (Poxton, 1999: 3).

The capacity of individuals to act is partially informed by the local organisational context within which they operate. Individuals' determination and creativity are insufficient if not supported by a wider commitment to developing new ways of working and organising for collaboration (Sullivan & Skelcher, 2002). Williams (2002) argues that theoretical and empirical fixations with the effectiveness and sustainability of interorganisational structures and mechanisms understates and neglects the pivotal contribution of individual actors in the collaborative process.

A host of factors have been identified which are supposed either to inhibit or facilitate collaboration, along with advice on how to 'do partnership' (Ling, 2000). Department of Health guidance (1999) itemises the ingredients deemed to be important: recognition and resolution of areas of conflict; agreement on a shared approach; development of strong leadership; continuous adaptation to reflect lessons learned; and incentives to reward good partnership work. Evans & Killoran's (2000) 'categories of enabling factors' lists: shared strategic vision; leadership and management; relations and local ownership; accountability; organisational readiness and responsiveness to changing environment. In their 'partnership assessment tool' Hardy et al (2000) list the following components of successful partnerships: recognise and accept the need for partnership; develop clarity and realism of purpose; ensure commitment and ownership; develop and maintain trust; create clear and robust partnership arrangements; monitor, measure and learn.

Williamson (2001) and Hardy et al (1992) propose categories of factors which may inhibit partnerships, such as : structural (geographical boundaries, management hierarchies), procedural (lines of accountability, different degrees of discretion); professional (values and cultures), financial (budgetary constraints), policy (different priorities, overlaps and gaps in services), legitimacy, status and concern with organisational self-preservation.

Powell et al (2001) reviewed the literature that has sought systematically to categorise and analyse the factors thought to facilitate and inhibit collaboration, and identified a significant degree of consensus between

academics and policy makers that key ingredients are shared vision, ownership and trust. Another factor widely considered to be important for collaboration is the role of the boundary-spanner (Williams, 2002).

The significance of these factors is by no means established beyond doubt. The lack of thorough evaluation of them as facilitators or inhibitors of collaboration is highlighted by Dowling et al (2004). This study aims to contribute to the evidence for or against their effectiveness.

2.8 Inner context: individual factors

This section examines individual factors of the inner context and why they might cultivate or hinder a particular instance of collaboration: the role of the boundary-spanner and the importance of trust.

2.8.1 Boundary-spanner

In the development of informal collaborative relationships built on trust and loyalty, the role of individuals with the personal and interpersonal skills to engender these is of key importance. The value of having the right person at the right time is a consistent message of interagency working (Hardy et al, 1992). Various terms are used to capture the qualities of 'the right person,' most frequently used is *boundary-spanner.*

Williams (2002) identifies several features of the boundary-spanner. The first is the reticulist or networker, defined by Friend et al (1974) as an individual who cultivates interpersonal relationships, communication, political skills and an appreciation of the interdependencies around the structure of problems and their potential solutions. Reticulists are "...especially sensitive to and skilled in bridging interests, professions and organisations" (Webb, 1991: 231). They play a number of key roles, including convenor, capacity-builder and catalyst (Himmelman, 1996). They play a crucial role in establishing and facilitating collaboration, taking a leadership role and supporting people within the collaboration throughout. They are trusted by a variety of partners, and this trust is important for reasons explored in the next section. They are able to bring networks together and help others identify relevant linkages between them and other actors. They identify where linkages are possible and build alliances with other committed and powerful individuals in their own and other organisations.

The networker's social bonding approach to collaboration can result in a blurring of professional and personal relationships which confers both advantages and disadvantages. The advantages are that it provides opportunities to share values and build trust (Ring & Van de Ven, 1994). The downsides of such informality, on the other hand, lie in the tensions of multiple accountabilities, the inherent fragility of personal relationships and the potential for exclusivity when in-groups are formed (LGMB, 1997).

Other facets of the boundary-spanner role are of the 'entrepreneur of power' with a strong commitment to change (Degeling, 1995), and the innovator who can engender "creativity, lateral thinking and an 'unlearning' of professional and organizational conventions and norms" (Williams, 2002: 110). He or she has the capacity to develop a more complex notion of social problems and broader, more inclusive solutions than the restrictive perspectives of any one profession or agency. They see the big picture and are able to identify the contributions different partners can make to shared goals. They are also able to see the opportunities and constraints offered by different contexts and how this might affect the behaviour of people within them.

Another is the 'cultural broker' (Trevillion, 1991) who invests effort in empathising with and respecting others' values and perspectives, and who is motivated to understand and value differences of culture, profession, role and 'gaze' (Williams, 2002). Related to this is the boundary spanner's skill as communicator, able to talk the right language whatever situation they are in. They empathise well, and this ability to see things from others' perspectives makes them good negotiators (Sullivan and Skelcher, 2002).

As leaders, boundary spanners are facilitative or catalytic rather than directive, asking the right questions and providing a spark for action rather than having the right answers and taking charge (Luke, 1998). They are able to influence and motivate others over whom they have little control, build trust between partners with different interests, perspectives and organisational imperatives, keep members committed to partnership while moving the wider agenda forward and maintain relationships and communication networks across agencies at a variety of levels (Ranade, 1998).

As is demonstrated in chapter three, the PCG's form and remit implied an array of circumstances in which reticulist skills would be of value in facilitating collaboration between different professional and occupational groups, within the PCG/T governing bodies and staff, across the primary care community and

in the wider organisational context. The variety of professions, interests and values was huge, as was the scope for misunderstanding and conflict. The benefit of boundary spanners' understanding of diverse viewpoints, engendering of trust and negotiating of collaborative actions is clear.

Equally clear is the need for innovator, cultural broker and leadership skills in the work of the PCG/T. Professional and managerial cultures in the PCG/T itself and within the primary care community are very different. The problem of health inequalities is a highly complex and challenging one which traditional processes and linear thinking are ill-suited to tackle. As was argued in section 2.4.1, the NHS alone cannot control all the factors which determine health in the broad sense: improving the health of a local population requires input from a range of organisations and agencies with very different cultures, perspectives and values. These skills are important too in negotiating collaboration between the very different values and cultures of the primary care professions and the managers involved with the PCG/T in developing primary care.

Where individuals are key to driving collaboration, the risk of losing energy, purpose, commitment and action along with the unplanned departure of those individuals is real (Hardy et al, 1996). However, despite this array of critical skills for the PCG and the PCT and in any situation where a complex policy problem is to be addressed, boundary spanners are often undervalued. In Ranade's (1998) research, boundary spanners from statutory organisations complained that time taken to perform their "network caretaking" role was never acknowledged or supported by their bosses. The value of this work was only acknowledged when illness or maternity leave disrupted it.

2.8.2 Trust

Trust is a defining feature of policy networks. Ling (2000: 83) distinguishes collaborations based on "...very trusting relationships, a sense of generosity of spirit, long-term reciprocity and a delight in the success of other partners" from those based on "cautious, short-term alliances which will be broken as soon as narrow sectional interests are compromised". Trust is widely cited as a crucial ingredient to begin and sustain collaboration (Himmelman, 1996). Webb asserts that:

> Attitudes of mistrust and suspicion are a primary barrier to co-operation between organisations and professional boundaries.

> Collaborative behaviour is hardly conceivable where trusting attitudes are absent (Webb, 1991: 237).

Trust is important in collaborative relationships because it provides a way of coping with risk or uncertainty in relationships with others, which may be high between groups of people who have not traditionally worked together (Lane & Bachmann, 1998). Yet its definition is contested, and the subject of the analysis of a range of disciplines (Williams, 2002). It is "... simultaneously the most self-evident and most elusive of the principles which underpin successful partnership working" (Hardy et al, 2003:28).

Trust has a reputation for fragility, being slow to build and quick to crumble (Hudson & Hardy, 2002; Powell & Exworthy, 2002). Alter and Hage (1993) understand that the propensity towards trusting relationships is context specific and possibly culturally specific. It can be undermined or limited in practice, rendering the nature of the collaboration correspondingly limited. Identifying the key elements of trusting contexts is important in supporting their development and reproducing them in the future (Sullivan & Skelcher, 2002).

Williams (2002) identifies similarities between the work of Bachmann (2001) who stresses the relationship between trust and control, both mechanisms for co-ordinating social interactions, and Hardy et al's (1998) distinction between real and simulated trust. Hardy et al attempt to disentangle the notions of trust and power, highlighting that "a rhetoric of collaboration can be used to promote vested interests through the manipulation and capitulation of weaker parties" (1998: 65)

The literature identifies a number of prerequisites for the establishment and maintenance of trust, some of which can be engineered, and some which cannot. Mayer et al (1995) identify three antecedents to trust between individuals:

- ability: confidence in the other person's skills, professional expertise and knowledge
- benevolence: a belief that he or she is altruistic and working in the public interest
- and integrity: belief that he or she will adhere to a set of moral principles.

These will not always be in place at the beginning of a collaborative venture, and may need to be developed over time.

Trust can also operate at an organisational level, where building it is dependent on agreement on modes of 'principled conduct' which means 'fair dealings' in relation to the distribution of benefits of collaboration, and 'fairness in procedure' (Cropper et al, 1996). Fair dealings means partners can feel confident that their respective contributions will be valued appropriately and that the benefits will be shared, and this relates closely to fairness in procedure. Cropper argues that collaborations need to agree ways of making decisions and working together that are acknowledged to be equitable by all.

Hudson & Hardy (2002) propose that the development of trust depends on a perception that the partners are equal in terms of status, and not necessarily in terms of resources. Where partners acknowledge and demonstrate altruism, and are prepared to make short-term sacrifices in the interests of the good of the partnership, trust is engendered. Hardy et al (2003) suggest that the resources which each organisation brings may appear to be unequal, but are different and not always readily quantifiable. Trust is fostered where each partner's contribution is equally recognised and valued. They claim that where trust is built in this way, openness, honesty and the acknowledgement of altruism, significant risk-taking is encouraged, and the partnership is likely to survive external problems.

Rummery (2002) argues that it evolves best through the experience of (preferably successful) joint working, and is developed and maintained more readily where the values and goals of organisations or individuals are similar. However, in the situations in which collaboration is arguably most needed, the values and goals of professions or organisations may not be similar and there may be perceptions of great inequalities of status. Until trust is established, organisations may be unwilling to make the short term sacrifices required to build it. As section 2.5.4 showed, differences in status, culture, values etc between different professional groups, agencies and sectors whose input is required to deliver primary care and to improve health, are significant and well documented.

Bond & Le Grand (2003) use game theory to explore trust in the relationship between GPs as trustors and the PCG/T as trustees, and the factors which will determine whether GPs will infer that PCG/Ts are trustworthy. The first factor is the likelihood that the relationship will continue in the long term, as a

trustee who is likely to move on has a greater incentive to violate trust. Since GPs, as independent contractors, have a financial investment in a geographically rooted practice, so are less mobile than a manager, they are more likely to be trusted on PCG/T boards than are managers. A second factor Bond & Le Grand highlight is the extent to which national priorities are subject to change. They argue that a stable policy environment should allow levels of perceived trustworthiness to rise, and thus that a manager in a stable policy environment should be perceived as more trustworthy than one working in a constantly changing one. The repetition of interaction is the third factor they identify. Again, as doctors are embedded in the local community they are likely to have repeated interactions with other GPs and so have more to lose by violating trust.

2.9 Inner context: organisational factors

2.9.1 Shared vision and clarity of purpose

Hudson (2000a) and Rummery (1998) highlight the importance of organisations and professionals having common, achievable goals. Common ground, in terms of a broad set of shared understandings as well as realistic aims and objectives are identified by Hardy et al (2003) as crucial for building successful partnerships. These may be in place from the beginning, or may be developed and refined over time. They concede that absolute clarity of purpose may in fact feel threatening early in the relationships, and some ambiguity may help generate commitment. But realism of purpose is essential if enthusiasm is to be maintained; it is wise to acknowledge that large scale change will not be accomplished quickly or simply, and that 'quick, small wins' can be motivating, if they are related to 'big wins'.

The Audit Commission (1998a) warns that partnerships are likely to fail when the goal is of interest to one agency only, the main aim is to achieve cost savings and shunt costs or blame, and the agencies or professionals have a poor history of joint working and little commitment to change this. Processes in which decision-making is devolved are likely to foster goals of interest to the organisations/agencies, whereas where collaboration is hierarchically imposed, it may not feature in anyone's 'vision' except insofar as they are incentivised to meet targets.

2.9.2 Ownership and accountability

Powell et al (2001) identify two ideal types of policy ownership: a 'dedicated' approach where responsibility for developing collaboration rests with a small group of key individuals and a 'diffuse' approach where responsibility is widely devolved through the agencies. They found evidence of some trade-off between seniority of leadership and width of ownership, and speculated that the attendance of senior managers at meetings, rather than more junior staff who would have to seek authority before committing to a decision, would lead to reliance on a few individual partnership champions. This, in turn could result in low ownership of the collaboration at junior levels.

Structural and organisational accountability systems may also impede partnerships between health and social care. For example, while the NHS is funded by national taxation, social services are funded through a combination of local and national taxation. Both are accountable upwards to central government, but accountability arrangements are more complex for social services departments, which are also accountable to local councillors.

2.10 Summary

The nature of transformations of the role of the state provides an illuminating backdrop to the proliferation of collaboration in the late 20th century. This chapter developed an account of shifts in the definition of the state's responsibilities – in the cohesion, concentration, fragmentation and co-ordination of the mechanisms which ensure they are met – to contextualise the introduction of the PCG and PCT.

From the inception of the NHS until the late 1990s, these changes led from an overloaded state, or quasi-hierarchy, to a hollowed-out state or quasi-market-driven mode of governance. Throughout these changes in the mode of governance in the public sector, GPs had fought to retain their independence. They resisted being part of a quasi-hierarchy and, where they had been involved in the quasi-marketplace, it had been voluntary. Their history was characterised by professional and organisational autonomy, an absence of collaboration or collective responsibility, and higher professional status than that of nurses or social workers.

By 1997 when the Labour government came to power, public services were in a state of fragmentation and ambiguous accountability. At the same time, the political focus was on "wicked issues" (Rittel and Weber, 1973) such as health inequalities, which cut across departmental and service boundaries. This fragmentation of the state and the complexity of the social problems it faced served to motivate collaboration. New Labour's response to these problems was to align themselves rhetorically with a collaborative discourse which resonated with networks, introducing PCGs and PCTs as part of a wider program of reform. But the rhetoric of collaboration and trust sat oddly alongside other elements of New Labour's modernisation agenda such as heavy managerial accountability and target-driven prescriptions for action.

Chapter three: Organisational forms of PCGs and PCTs

3.1 Overview

Chapter two provided an overview of the political, social and historical context in which New Labour's health and social policy were formulated. A key element of this policy was the introduction of the Primary Care Group (PCG) and Primary Care Trust (PCT), new primary care organisations which appeared to embody many features of New Labour's third way.

This chapter explores the organisational forms of the PCG and PCT – as they were prescribed by the Department of Health and NHS Executive – in the light of this context.

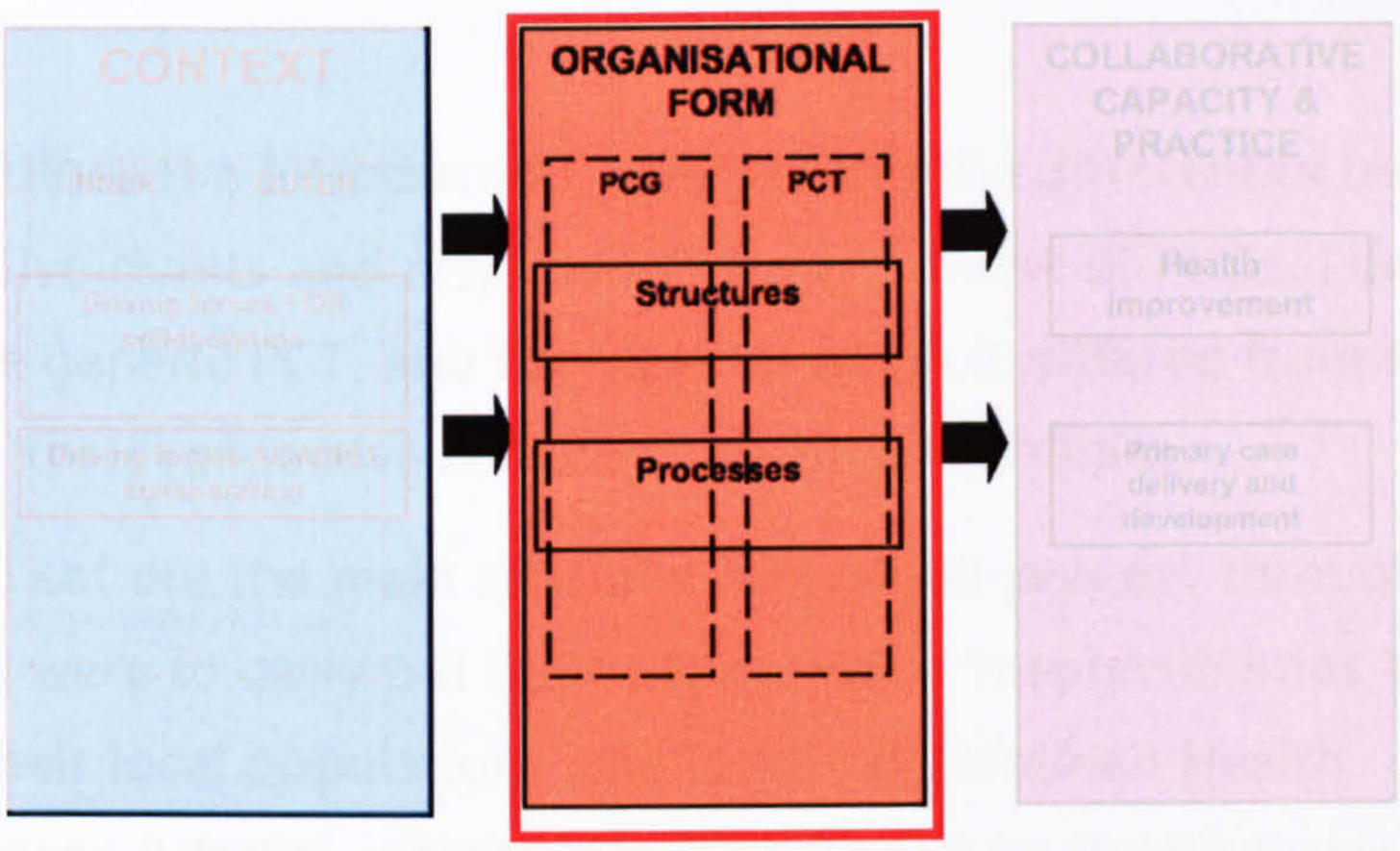

Figure 3: Realist theoretical framework – organisational form

How did they fit with New Labour's collaborative discourse, and how well were they suited to meeting their responsibilities to deliver primary care and improve health. Organisational *form* refers to the structures and processes within organisations. S*tructures* are the ordering devices (e.g. governance and reporting mechanisms) by which organisations produce collective action. *Processes* consist of people in an organisation using its structures both officially and unofficially to instigate others to undertake a joint action (Sullivan and Skelcher, 2002).

This chapter asks whether the structures and processes of PCGs and PCTs were well suited to address those aspects of the political and professional context which had previously militated against collaboration. In what ways would these collaborations reinforce and challenge the existing institutional architecture?

For example, would they be designed to rectify the organisational fragmentation of the primary care community. Would they aim to bridge the cultural and organisational divides between the local primary care community and the local authority? Would their organisational forms lend them potential to facilitate the development of collaborative relationships built on trust, loyalty and reciprosity to address complex social problems?

Section 3.2 provides a brief overview of the introduction of PCGs in England, outlining the general remit and more specific organisational responsibilities of the generic PCG. Their responsibilities included developing primary care and improving their population's health, both of which required collaboration. I provide an account of the structure of the generic PCG, as far as this was centrally prescribed, highlighting three radical features of this new structure which had implications for collaboration: the dominance of clinicians on its board, the inclusion of a social services representative on the board and the unified budget.

Section 3.3 outlines the introduction of PCTs, and the differences between their collaborative remits and responsibilities and those of PCGs. I describe the structure of the generic PCT, and the ways in which it differed from the PCG with respect to their respective collaborative responsibilities.

In **section 3.4** I set out the main centrally prescribed process through which PCGs and PCTs were to carry out their collaborative responsibilities to improve the health of their local populations: the locally determined Health Improvement Plans (HImPs), which were superseded by Health Improvement and Modernisation Plans (HIMPs), and Local Development Plans (LDPs).

Section 3.5 examines the process of clinical governance which provided a framework for much of PCGs' and PCTs collaborative work to deliver and develop primary care services.

Finally, **section 3.6** draws out from chapters two and three the main features of the context and organisational forms of the PCG and PCT relating to collaboration. From these it develops an analytic framework which points to four further research questions which help to structure the enquiry and analysis in this research.

3.2 PCG structure

PCGs were the basic building blocks of the new NHS (Klein, 2001), and their existence was mandatory. In 1999, 481 of these groups brought together, for the first time, all the GPs and other primary care providers in a given geographical area, covering average populations of around 100,000 (Bojke et al, 2001). Their boundaries were to be coterminous, where possible, with local authority boundaries. PCGs managed a budget for their population's share of all NHS services, although they were formally still part of their local Health Authority.

They were tasked with: providing and developing primary and community services; and with improving the health of the community and reducing inequalities (DH, 1998b). These duties depended on collaborative working predominantly internally within primary care, and externally with other organisations respectively.

This new model of primary care organisation provided a structure which aimed to lend cohesion to the primary care community in a locality, and to bring primary care together with other local health and social care organisations. This was a key change to the way primary care was organised. This model sought to address poor collaborative working arrangements, to encourage developments in primary and community services and a public health focus. It implied an unprecedented 'corporate imperative' in primary care which emphasised collective responsibility for delivering services, spending a budget and improving health. New budgetary and clinical governance arrangements meant the PCG had to persuade its constituent practitioners to operate with a sense of shared responsibility, purpose and identity.

This section examines how PCGs' organisational structures were designed to enable collaboration within primary care and between it and other organisations. In particular, it examines how, and to what extent, they challenged the status quo in ways which would overcome the contextual factors which had inhibited collaboration, as set out in chapter two. The very existence of a locality-based primary care organisation was new, and had implications for the development of a sense of corporacy within the primary care community.

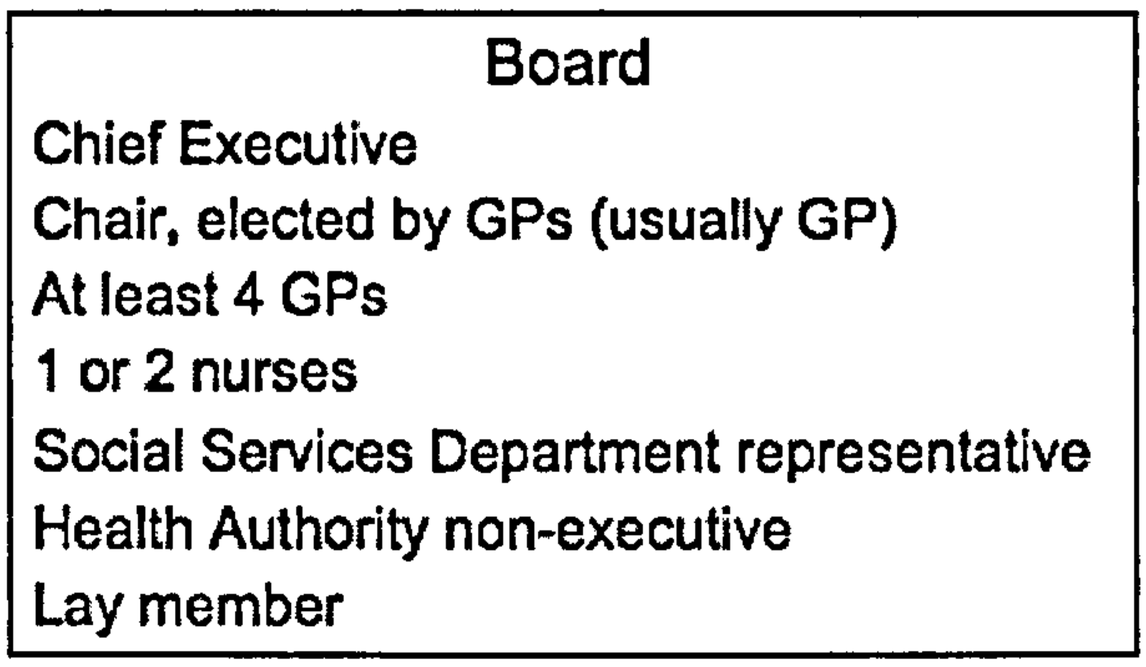

Figure 4: Structure of generic Primary Care Group

The structure of PCGs (figure 4) was broadly prescribed by the Department of Health although some elements could be determined locally within certain parameters, for example, the size and precise configuration of the board. The guidance for PCG board membership emphasised a leadership role for primary care professionals: "The composition of Primary Care Group boards reflects the need to ensure that family doctors and community nurses will be in the lead" (NHSE, 1998b, para 13).

PCGs were led by a board composed largely of clinicians, most had a number of subgroups/working groups to which projects were delegated, and they employed a staff team. The PCG structure partially challenged the *status quo* in terms of the relationships between individuals and professional groups. Two radical features of the new model of primary care organisation lay in the PCG board configuration. First, doctors and nurses occupied positions on the governing board. Second, a social services representative was included on the governing board. A third change was the organisations' budgetary arrangements. These differed significantly from the arrangements which preceded them, and had implications for the collaborative relationships within the PCG itself and between the PCG and other organisations.

3.2.1 Locality-based primary care organisation

The very existence of a locality-based primary care organisation represented an attempt to introduce to primary care a corporate culture that emphasised collective responsibility (Wilkin et al, 2001). As chapter two showed (see p27),

prior to the 1997 NHS (Primary Care) Act no single body was charged with representing the diverse primary care organisations in a locality (Glendinning & Rummery, 1997). There was a poor record on joint working with other health care agencies and especially with social care. Traditionally, organisations within primary care (mainly general practice) tended to operate in isolation from others, and did not easily engage as a corporate organisation with a sense of shared identity and purpose. The primary care culture of the 1990s was characterised by the development of services in isolation and a culture of competition brought about by quasi-internal market forces in the health system. Individual primary care practitioners had developed working relationships with workers in these other agencies but there had been little development of more structured partnerships (Audit Commission, 1986 and Nocon, 1994, cited in Clarke & Glendinning 2002, p35).

In contrast, the cultural climate of primary care from 1997 was to be more corporate, emphasising collaboration. The PCG provided an organisational structure which brought together general practices and other health and social care organisations. The budgetary and clinical governance arrangements of PCGs and PCTs implied a level of interdependency and common interest within primary care communities which was quite different from the relationships between practices in the past. Their establishment was an attempt to foster local ownership and control (DH, 1997; Wilkin et al, 2001). This was a key change to the organisation of primary care aimed at addressing poor collaborative working arrangements, to encourage developments in primary and community services and a public health focus. They provided, for the first time, an organisational structure which represented the primary care community in a locality, and brought it together with other health and social care organisations. The board was expected to take a corporate view which went beyond its membership and was inclusive of "all those who have a legitimate interest and wish to be involved in the policy and decision making process" (NHSE 1998b para 27).

Cohesion and a sense of local ownership and control in a primary care community would have a number of potential advantages over the fragmentation of the previous situation. It would mean a more strategic approach to improving the quality of primary care, for example allocating the budget and sharing good practice across practices and across professional groups, allowing strategic decisions to be made more democratically and on

the basis of a truer understanding of the local needs and strengths of the primary care community as a whole. It would strengthen and unify the voice of primary care in negotiations with other organisations such as acute hospital trusts and local authority departments in commissioning or co-ordinating services, facilitating a more coherent and persuasive voice and allowing economies of scale compared with GP fundholding. A cohesive primary care community could better manage the proposed shift in health care delivery from secondary to primary care in such a way that it was well executed, adequately resourced and that primary care was protected from the shifting of responsibilities without sufficient resources. It would also locate responsibility, accountability and authority for the activities of primary care.

3.2.2 Clinicians as board members

As chapter two set out (see 2.5.4), the relationship between professionals and managers in the NHS was often characterised by degrees of antagonism, and primary care had remained largely unmanaged. Manager-professional roles had been blurred prior to the introduction of PCGs, but mainly in secondary care. While the majority of GPs were independent contractors and thus, in a sense, managed small businesses, these managerial responsibilities had not extended beyond their individual practices. However, the vision for a more corporate primary care with shared responsibilities, as set out in the *New NHS: Modern, Dependable* (Secretary of State for Health, 1997), implied a need for co-ordination on a greater scale.

New Labour's approach to this was manifestly 'third way'. It avoided introducing a new hierarchical level of management. Instead the organisational structure of PCGs was designed to facilitate co-operation between professionals themselves by allowing them to elect members to strategic positions on the board. NHSE guidance (NHSE, 1998a) stipulated that PCGs would be led by a board comprising a chief executive, at least four GPs, one or two community nurses, a Health Authority non-executive representative, a social services representative and a lay member. Thus, New Labour did not attempt to change the behaviour of primary care professionals through coercion by managers. Instead, the domination of the board by elected clinicians gave professionals strategic influence and meant that the primary care community was managed at the locality level by professional managers rather than by the traditional lay managers. Of course, clinician board

members were not managers in the sense that they managed staff, but they were involved in strategic decisions which would normally have been considered the remit of NHS managers.

The PCG's remit for health improvement and development of primary care implied that much of the work it undertook would require collaboration in some form – whether within the primary care community or with external bodies. The composition of its governing board, predominantly professional clinicians, appeared to bring a number of potentially advantageous implications for its capacity to foster collaboration. First, the professionals who shaped local policy would maintain contact with patients and closeness to local issues through their practice. The policies, and any collaboration which developed to implement them, would thus be responsive to local need as they perceived it. Also, they would have current, first hand experience of the promises and pitfalls of operational level working (or not) with other agencies. At the same time their effectiveness and credibility as 'managers' would be enhanced by maintaining identity with their professional peers in the local primary care community who had elected them (Peckham, 2003).

PCG/T chairs recognised that the support of primary care professionals was fundamental to the success of their organisations (Dowling et al, 2003). According to the National Tracker Survey (Wilkin et al, 2002) 97% of board chairs rated the support of local GPs as important to the success of the PCG/T and 90% rated the support of nurses as important. Between 1999/2000 and 2001/02, the proportion of chairs who thought at least half of their local GPs were supportive rose from 40% to 61%. The National Tracker Survey also examined PCG/T chairs' perceptions of the extent to which the interests of different stakeholder groups were represented in the decision-making processes of the boards. This declined slightly from 2000/1 to 2001/02 for both GPs and community nurses.

However, this model brought potential disadvantages as well as advantages. Practicing clinicians lacked experience of management and strategic collaborative working and an understanding of partner organisations' cultures (Williamson, 2001). Critics of the PCG model asserted that such management skills are distinct from (and may even be incompatible with) clinical skills; GPs and other clinicians should not be expected naturally to bring them. Even NHSE guidance conceded this was a potential drawback of the model.

> Primary Care Group Boards will bring together doctors and nurses who may have experience of operating in clinical teams and jointly providing care packages but for whom the experience of joint governance will be a new task. Similarly PCG Boards will also bring together lay members, Social Services managers with doctors and nurses for the first time to share the governing responsibilities. (NHSE, 1998b, para 24)

Both doctors and nurses had places on the PCG board and policy guidance for the board membership of the PCG prescribed a joint leadership role for doctors and nurses. However, traditionally, medicine has wielded greater power and status than nursing and the medical profession has held a clear view of the subordinate position of nursing in patient care (Drennan, 2004). Accordingly, the British Medical Association was able to exert pressure on the Department of Health to secure agreement that GPs would constitute the majority group on PCG boards, and be allowed to nominate the chair. So, while on one hand the inclusion on a board of both professional groups as members with equal status challenged the traditional power differential between them, on the other the overall composition undermined this challenge, with GPs (traditionally the most dominant professional group in primary care) being entitled to up to seven places on the board compared to nurses' one or two places. This was consistent with the established powerbase of doctors, which remained a crucial factor in the organisational context of change in the NHS. Hudson & Hardy (2002) suggest a perception of equality of status is a prerequisite of the trust required for collaboration, and this was only partially implied by the composition of the PCG board.

3.2.3 Links with social services

The second radical structural feature of the PCG model was the inclusion on its board of a social services department (SSD) representative. According to the White Paper *The New NHS Modern, Dependable*, PCGs were to "...better integrate primary and community health services and work more closely with Social Services on both planning and delivery" (Secretary of State for Health, 1997, para 5.9). Guidance published the following year stated that "...the involvement of local government in the governance of PCGs will underpin the establishment of new partnership between primary and social care" (NHSE, 1998a, para 21), and that PCG Boards were to:

> ...bring together lay members, Social Services managers with doctors and nurses for the first time to share the governing responsibilities. A Primary Care Group will also need to build up its partnership with the wider local government authorities. (NHSE, 1998a para 24).

As Glendinning et al (2001) observe, there is evidence that the history of partnerships between health and local authorities is patchy (Nocon, 1994; House of Commons Health Committee, 1998).

The inclusion of an SSD representative on a PCG board was primarily designed to underpin collaboration between health and social services. The capacity of the representative to do so, however, was doubtful, due in part to differences between the organisation of primary care and of social services.

First, differences in organisational structures made it difficult to match the clinicians and the SSD representative in terms of their status and strategic level. The background and status of the appropriate board representative was not prescribed by the Department of Health (Hudson, 2000), although it was initially recommended that they should be managers with operational responsibilities:

> The choice of officer will depend on the configuration of Primary Care Groups and the local circumstances in which social services are organised, but in many cases the officer will be an operational manager. (NHSE 1998a, para 21)

This would be consistent with the practitioner status of the nurse and GP representative, and would, possibly, facilitate alignment of front line services (Glendinning et al, 2003). However, most social services representatives on PCG boards had some senior strategic management responsibilities (National Tracker survey, Coleman & Glendinning, 2002). While more senior social services managers had greater influence within their organisations, they had limited client contact so were not practitioners as were their doctor and nurse colleagues on the board. More junior SSD managers, on the other hand, had operational responsibilities but less authority and strategic influence within their department.

Hudson et al (1999) argue that the more senior the SSD representation, the more likely links will be made to other areas of the local authority. About ten percent of PCGs had a Chief Officer or Director as SSD representative, and a further third had a representative at assistant director level. In such cases the

representative might be expected to have some remit to speak on behalf of the SSD and make decisions without routine referral back to the local authority.

Second, the differences between the organisation of health and social care led initially to uncertainties on both sides about the ways the other worked. The national tracker survey of PCGs and PCTs identified a gulf in understanding between social services representatives and primary care practitioners of the ways the other functioned and their responsibilities. The PCG seemed to have a beneficial influence on this interorganisational understanding as the proportion of social services representatives who reported an improvement in understanding and in their relationships with the other board members rose from 58% in 1999 to 77% in 2000 (Coleman & Glendinning, 2002).

Despite this, evidence of the influence of the inclusion of the SSD representative on collaborative work was not promising and the improvement in relationships appeared not to be translated into actual collaborative work. GPs' perceptions of the influence of SSD representatives on the activities of PCGs and PCTs was low: in 1999 54% of GPs, and in 2000 44% reported that SSD representatives had little or no influence. This probably reflected the clinical and organisational preoccupations of the boards as they established themselves (Wilkin et al, 2002).

NHSE guidance saw the SSD representative as "acting as a conduit between the PCG and Social Services" (NHSE, 1998: para 76). However, Hudson et al (1999: 141) reported that "...it was not possible to discern any specific processes or mechanisms which had been developed to ensure the social services representative fed back to and consulted wither a professional or organisational constituency."

The National Tracker Survey findings suggested that the representation of social services departments on PCG boards was not effective in joint planning and commissioning of services, which seemed surprising given the policy emphasis on reducing delays in discharge and preventing admissions to hospital (Glendinning et al, 2003). By 2000/01 two thirds of PCGs had a subgroup with specific responsibilities for commissioning hospital and community health services, but only two fifths of these had social services representation (Glendinning et al, 2001a). Most PCGs did not take responsibility for commissioning older people's services from their local Health Authorities before they were abolished in 2002, at which point commissioning responsibilities were transferred to PCTs (Wilkin et al, 2002). In 2002, PCTs

were commissioning a range of services jointly with social services partners, such as community-based rehabilitation schemes, joint care management, rapid response home care services and joint equipment services (Glendinning et al, 2003).

Nationally, legislation, resources, and guidance was introduced to facilitate collaboration between NHS bodies and SSDs. National Service Priorities were identified for joint working, particularly in relation to services for older and disabled people (DH, 1998c). New joint investment plans required joint commissioning of services for older people and people with disabilities or mental illness (DH, 2000). Resources were earmarked in the Social Services Modernisation Fund to foster partnerships between health and social services (DH 1999e)

This approach to facilitating collaboration between health and social care was replaced by the announcement in *The NHS Plan* (Secretary of State for Health, 2000) of integrated bodies called care trusts: a level of PCT which would provide or commission social care as well as health care. They would be imposed where the more facilitative approach to encouraging collaboration had been unsuccessful.

The Health Act Flexibilities brought in in 2000 removed some of the structural barriers to closer inter-agency collaboration by allowing NHS organisations and local authorities to pool budgets for specific services, delegate commissioning responsibilities to a single 'lead' organisation and employ health and social services staff within the same organisation. PCTs, but not PCGs had appropriate status to sign such partnerships (Glendinning et al, 2003).

Not only was the SSD representative expected to act as a conduit between the PCG/T and social services, early guidance suggested that he or she would be "well placed" to advise on how these wider partnerships can be established and "...may be able to act as a gateway to other local government departments such as environmental health, housing and education" (NHS Executive, 1998: para 77). Hudson (2000) found optimism that locality focus of PCGs allows a more detailed and localised analysis of the needs of populations. It was envisaged that, depending on the organizational structure and communication channels of the employing authority, they may also be able to facilitate linkages between the PCG and wider local authority services and functions which have an impact on the quality of life of local communities (Glendinning

et al, 2001: 414). This would be less likely to occur in two-tier than unitary local authorities, where scope for working across boundaries would be limited (Hudson, 2000).

PCGs found other ways of connecting with their local authorities: they could co-opt other local authority officers to the board as associate members but with no right to vote, or board members can share their vote with a colleague from the same organisation or profession. About 10% of PCGs had additional representation from Local Authority representation from officers other than those in SSD. This is an interesting indication of the extent to which the role of local government in the health of a locality is recognised to stretch beyond the more traditional intersection with social services (Hudson, 2000).

As section 2.6.3 showed, a degree of organisational stability is conducive to building collaborative relationships. The pace of organisational change and absence of geographical coterminosity between PCGs and social services departments were a barrier to collaboration between the two organisations (Glendinning et al, 2003). Even following the mergers of PCGs, boundary differences were cited as a barrier to closer partnerships by a fifth of PCG/Ts (Coleman & Glendinning, 2002). Organisational turbulence also took its toll: The National Tracker Survey found the turnover of social services representatives to be high. In 2002, even of those PCG/Ts who had not undergone mergers, 39% had social services representatives who had been in post less than one year. The detrimental influence of organisational turbulence on organisations' capacity to develop collaborative relationships is well documented (Hudson et al, 1999; Coleman & Glendinning, 2002) particularly in public health activity (Abbott et al, 2001; Gillam et al, 2001). The disruption of relationships which occurs when individuals move to and from organisations may be a factor in inhibiting collaborative capacity.

3.2.4 Budget

A third feature of the PCG model which differed significantly from the previous organisation of primary care, and which had implications for collaboration, was that it was to operate within a "single cash-limited envelope." This meant that a budget for each PCG was calculated to cover their population's share of all NHS services including prescribing costs, although responsibility for spending this budget was devolved gradually to PCGs by district Health Authorities.

This arrangement called for collaboration within primary care communities in a locality to negotiate and, if necessary, to discipline each other in their collective economic behaviour. As chapter two discussed, the GP fundholding (GPFH) scheme introduced by the previous Conservative government had set some precedent for this. Under GPFH, budgets had been allocated to individual practices which could choose how to spend them on primary and secondary care services. Total purchasing pilots (TPPs) had freedoms to buy a wider range of services than GPFH. Under some TPP arrangements groups of practices would voluntarily pool their budgets to purchase together as a more powerful economic unit than they could as individual practices (Mays et al, 1998),. However, mandatory arrangements with collective financial responsibilities at the locality level were quite unprecedented in primary care.

Prescribing costs, which had not previously been included in NHS budgets because they were considered to be demand-led and thus uncontrollable, had been included in the budgets set for GP fundholders, and fundholding had shown that prescribing could be controlled. Klein (2001) argues that PCGs' unitary budget was the result of New Labour's wish to universalise locality commissioning and the budgetary discipline of fundholding, and exemplified their 'what works' approach to policy-making. However, a clear collaborative mechanism through which budgets would be allocated between practices was absent (Bond & Le Grand, 2003). It was up to each PCG to work out for themselves how to regulate and discipline the economic behaviour of their constituent practices.

3.3 PCT structure

It was intended that all PCGs would become PCTs by 2004 (Secretary of State for Health, 2000 para 7.8); this transition was universal by 2002. The publication of *Shifting the Balance of Power* (DH, 2001) brought about the transition much earlier than the government's original target. In many cases, two or more PCGs merged in the transition to become one PCT. PCTs inherited PCGs' three main tasks but were freestanding bodies, independent from, but still accountable to, the local Health Authority. They were larger organisations than their predecessors with additional responsibilities, and their structures were correspondingly more complex and their processes more formal. They could employ their own clinical staff, and had responsibility for a greater

devolved budget to purchase secondary care for their population and to provide a range of community health services.

Board
Chief Executive
Lay Chair
6 lay members
Director of Finance
Chair of Professional Executive Committee
1 GP from PEC
1 nurse from PEC
Director of Public Health

Professional Executive Committee
Chief Executive
Chair, elected by GPs (usually GP)
Social Services Department representative
Director of Public Health
Flexibility in clinician membership – up to 10 clinicians: GPs, local community nurses and other community professionals

Subgroups of the board

Managerial staff

Administrative staff

Figure 5: Structure of generic Primary Care Trust

3.3.1 Integration of primary and community services

Unlike PCGs, PCTs assumed responsibility for running community hospitals and employing staff previously employed by the Community Health Trust. The integration of primary and community services in PCTs had two potential consequences. First, it presented an opportunity to overcome some of the problems of collaboration within primary care which stemmed from practitioners' historically working for separate organisations, with different systems of accountability and remuneration (Clarke & Rummery, 2002). It was anticipated that an advantage of directly employing community nursing staff and bringing them into the same organisation as practice-based primary care professionals was that patients could be brought more cohesive packages of care by making best use of specialist skills across all disciplines.

Second, having greater resources, a wider remit, and more devolved powers and responsibilities than a PCG, the PCT was expected to be more influential with other organisations when negotiating resources, action and service provision. PCTs' unusual status as both provider and commissioner of services was potentially a strength in that it could exert influence over organisations from which it commissioned services, while its locality base would allow it to be flexible enough to respond to local need.

3.3.2 Separation of the board from the professional executive committee

PCTs had a more complex governance structure than PCGs. PCTs were two-tiered, as the functions of the PCT board were separated from the professional executive committee (PEC). This, to some degree, represented a capitulation from the PCG's blurred professional-manager boundaries, handing back responsibility for some elements of governance from clinicians to non-clinicians. The PCT board was predominantly lay, and was appointed by the NHS Appointments Commission rather than elected. It was primarily responsible for effective corporate governance, overseeing the work of the PEC and for ensuring probity, public involvement and public accountability. It was composed of a lay chair, a chief executive, six lay members and a Director of Finance. Additionally, it included a nurse representative, a GP representative and the chair of the PEC.

The PEC led the commissioning of services, oversaw the development and delivery of primary and community services and managed the PCT's resources. It was accountable to the board for complying with NHS regulations, delivering the terms of annual accountability agreements, and maintaining an effective strategic base. PCTs were allowed "greater flexibility in the balance of professional members to reflect the configuration and range of services provided by the trust" (NHSE, 1999:13). It was largely composed of health professionals and an SSD representative, but the dominance of GPs was reduced compared to PCGs and it included a broader range of primary care professionals such as pharmacists. Like PCG boards, PCT PECs and boards were expected to have a number of sub-committees and work groups to which much of the day-to-day work of the PCT would be delegated.

However, there were concerns that, as larger organisations, PCTs might become more distant, like Health Authorities, arguably undermining some of the strengths of PCGs which lay in being local, small and close to the ground. There were concerns, too, that the weight of policy initiatives, structural changes and centrally imposed targets might reduce PCTs' scope to care for patients (Gillam et al, 2001). PCT chief executives recognised that PCTs were becoming more remote from key stakeholders, with a loss of local focus, and the challenges of managing organisational change (Dowling et al, 2003).

The survey results also indicated that the transition from PCG to PCT status led to an increased concentration of power and influence in the officers of the organisation and a corresponding decline in the influence of broader

professional constituencies. A much lower proportion of PCG board chairs (12%) than PCT executive committee chairs (30%) rated local GPs as having little or no influence (Smith et al, 2002).

3.4 Processes for health improvement

As chapter two showed, the New Labour government professed a commitment to health improvement and reducing health inequalities, and this was identified as one of PCGs' main tasks, distinguished in the PCG guidance from developing primary care and community care and commissioning hospital services.

The term "health improvement" indicates an approach to the health of a population rather than to illness (Gillam et al 2001). The responsibility to improve the population's health required PCGs and PCTs to adopt this new perspective to primary care rather than one which focussed on individuals' illness.

> Health improvement includes activities to promote health that occur outside the NHS (for example, in workplaces and schools) as well as activities that address social, economic, and environmental influences on health (for example, housing, transport, employment, and community development) (Gillam et al, 2001, p323).

Hunter (2003) identifies a struggle between 'upstream' strategies for health improvement, which are concerned with addressing determinants of health, and 'downstream' ones which focus on health care. Within the NHS, downstream strategies had dominated. Because of this, health improvement was perhaps the most radical of the three remits of PCGs and PCTs, as it implied a refocusing of general practice from its traditional perspective which was a predominantly reactive medical one (Pratt, 1995, Taylor et al, 1998) to a broader public health one. The most commonly accepted definition of public health in the UK is that adopted by, for example, the Wanless Report on the future of public health: "the science and art of preventing disease, prolonging life and promoting health through organised efforts of society" (Wanless, 2002)

This section describes the centrally prescribed collaborative processes through which PCGs' and PCTs' responsibilities to improve the health of their local population were to be met: the Health Improvement Plan (HImP), the Health

Improvement and Modernisation Programme (HIMP) and the Local Development Plan (LDP).

There was renewed recognition that "connected problems require joined-up solutions" (Secretary of State for Health, 1998: para 1.12). General practice had a particularly poor record of collaboration (Taylor et al, 1998; Meads et al, 1999). Primary care organisations were required to combine their efforts with other health, social care and wider public health organisations. They were charged with building better healthy alliances between GPs and the wider health community, for example with local schools, voluntary bodies and across local government (NHSE, 1998a). The collaborations which were to grow around new PCGs were in part a pragmatic response to the complexity of the problems they, with their newly broadened health improvement remit, were expected to address, as well as to the increasing complexity of society (Casto, 1994).

The National Tracker Survey found that in 2000 two thirds of PCGs and PCTs had a subgroup that focussed on health improvement (Wilkin et al, 2000). The duty of PCGs to improve the health of their populations raised questions about the appropriate roles of the public health workforce, of primary care staff and of other local workers. The Chief Medical Officer's (2001) report recognised the public health role of primary care staff, local authority staff and people in the wider community (Peckham, 2003). Popay (2001), however, warned that there was little if any evidence from previous research or practice that primary care organisations or medical practitioners had the capacity or the inclination to do this. Primary care may have a role to play in reducing inequalities in access to primary care and working to diminish the 'inverse care law' which states that that the availability of good medical care tends to vary inversely with the need of the population served (Tudor-Hart, 1988). Traditional health promotion techniques focussed on the behaviour of individuals while neglecting other factors in the environment (Butterfoss, 1993). But to the extent that the causes of health inequalities are related also to wider socioeconomic or environmental factors, there was a lack of clarity about the role that primary care could play in tackling them (Peckham, 2003).

3.4.1 Health Improvement Plan

The main process through which PCGs were to improve the health of their community was the Health Improvement Programme (HImP). HImPs were the

local plan of action to improve health and modernise services which brought together the local NHS with Local Authorities and others including the voluntary sector to set the strategic framework for improving health and tackling inequalities. The White Paper, *Saving Lives: our healthier nation* set out the role PCGs were required to play in the development of local health improvement programmes: "they will forge powerful local partnerships with local bodies ... to deliver shared health goals. They will shape the health improvement programme and draw up their own plans of implementing it and for hitting the targets in it" (Secretary of State for Health, 1999: 122).

The perspectives and expertise of PCGs, hospital clinicians and the local community and its leaders were to influence the strategy (NHSE, 1998c, para 1). HImPs' long term objectives needed to be protected from a crisis management approach to budget planning and service demands (Hudson, 1999b). They were to set out locally defined objectives and include measurable targets to improve the health of everyone, to improve the health of the worst off in society and close the health gap.

The Health Development Agency (HDA) conducted a national review of HImPs and concluded that their effectiveness was limited by the timescale to which they had to be produced, and the constraints this placed on a meaningful consultation and involvement process during its production (Gillam & Florin, 2002). Hunter (2003) reviewed the various analyses of the impact of HImPs which found great variety in various of their characteristics, including the degree of involvement of partner agencies, breadth of the agenda and degree of partnership with the local authority in relation to wider determinants of health. Hunter & Killoran (2004) found HImPs were not seen as central to the work of PCG/Ts, who found them sometimes abstract and insufficiently action-oriented. Tensions between clinical and environmental or social priorities hindered their progress. Their emphasis was, in many cases, still found to be medically dominated and hijacked by the acute sector (Hunter, 2003) and ineffective in tackling "upstream" public health issues such as housing and transport (HDA, 2000). Other impediments to their achievements were that resources for HImPs were not prioritised. Further, they had insufficient time to mature before they were superseded by Health Improvement and Modernisation Plans (HIMPs), which meant that ownership of the HImP process, and clarity concerning responsibility for its implementation were not consolidated (Hunter et al, 2000).

3.4.2 Health Improvement and Modernisation Programme and Local Development Plan

When PCTs were established and local Health Authorities abolished, public health functions were integrated into PCTs, and Strategic Health Authorities adopted a performance management and review role (DH 2001, 2002). As PCTs replaced PCGs, HIMPs replaced HImPs. HIMPs were to set the strategic framework for improving health in a locality, and to set out high level objectives, measurable targets for improvement, and outcomes. From April 2002, PCTs had lead responsibility for HIMPs. Whereas priorites for the HImP had been established locally, HIMP priorities were those set out in the national *NHS Plan*, and PCTs were explicitly performance managed against them.

NHS Plan

The *NHS Plan* (Secretary of State for Health, 2000) became the driving force behind most of the NHS's work. It acknowledged that the NHS's inability to forge collaborative relationships with local authorities, business and community organisations had inhibited its efforts to tackle health inequalities. It prescribed a set of priority areas of work, and targets which were largely medical and quantifiable, and was structured around the following priority areas:

- access
- cancer
- capital and capacity
- coronary heart disease
- children
- mental health
- quality
- older people
- workforce planning
- information
- prevention of inequality and disability

A plethora of performance indicators was identified by the Department of Health to underpin the performance improvement agenda outlined in chapter six of the *NHS Plan* (Secretary of State for Health, 2000). The key performance indicators for health improvement against which the PCT was to be judged were predominantly medical: death rate from circulatory diseases, sexual

health as measured by the diagnosis rate of gonorrhoea, four week smoking quitters, conceptions below 18, cervical cancer screening, childhood immunisations and flu vaccinations.

The centre was to play a more active role in shaping performance at the periphery. Evidence-based National Service Frameworks were produced as templates for the organisation of services. National Institute for Clinical Excellence (NICE) would promote, bring together and diffuse evidence about good practice. The Commission for Health Improvement (CHI) would monitor progress towards achieving the Government's programme for quality. (Klein, 2001). "Star ratings" were awarded to trusts according to how well they performed against performance indicators set by the Commission for Health Improvement. The proliferation of central targets contained in the *NHS Plan* and NSF publications increased the tension between national and local priorities and threatened to swamp the local objectives and priorities identified in the first round of the HImPs (Hunter, 2003).

However, HIMPs themselves were shortlived, and were abruptly subsumed by Local Development Plans (LDPs). Reducing health inequalities was one of the stated priorities of LDPs, but in the guidance which accompanied them (DH, 2002) little was made of the distinction between health and health care, whereas they were clearly intended to deliver on the goals and targets of the *NHS Plan* (Secretary of State for Health, 2000). While HImPs and HIMPs were clearly dependent on collaboration between PCG/Ts and the range of local authority departments, LDPs made no mention of local authority departments other than social services. Neither did they require sign-up from voluntary sector partners. Once again, the emphasis was on collaboration with parts of local councils which had direct contributions to make to the problems surrounding access and discharge to hospitals and bed-blocking, and away from the broader public health roles of their other local authority departments.

In 2001 Local Strategic Partnerships (LSPs) were announced. These would be cross-agency, umbrella partnerships with a broad remit to improve the quality of life of local communities (DETR, 2001), and would be led, but not owned, by local authorities (Glendinning et al, 2003).

Overall, the move from PCG to PCT status shifted the organisations' focus from responding to local needs and demands to national targets, priorities and central government directives (Abbot et al, 2001; Heller, 2002). PCTs struggled to balance the demanding and specific demands of meeting targets to reduce

waiting times, with broader, less performance-managed requirements to break cycles of inequality (Evans, 2004).

3.5 Processes for delivery and development of primary care

This section describes the centrally prescribed collaborative processes through which PCGs' and PCTs' responsibilities to develop and deliver primary care were to be met. Clinical governance was the element of New Labour's modernisation agenda through which PCGs and PCTs were expected to assure the quality of primary care services. Through the clinical governance system "NHS organisations are accountable for continuously improving the quality of their services, safeguarding high standards by creating an environment in which excellence in clinical care will flourish" (DH, 1998b: 33). It was to address inconsistencies and unacceptable variations in the quality of practice, to enhance the efficiency and effectiveness of care and ensure the accountability of professionals (Campbell & Roland, 2003).

The majority of GPs were independent contractors with no line management system, whose largest unit of operation was their practice. Other than where doctors' fitness to practice was called into question, GPs' day-to-day practice had not been closely regulated by any external body, and considerable variations in provision existed within individual localities.

Just as the budgetary arrangements meant PCGs had to contain the cost of health care by constraining the spending of their constituent practitioners, through clinical governance they took on major responsibility to constrain clinical behaviour in the primary care sector and had to persuade their previously independent and relatively unregulated constituent practitioners to operate in a corporate way with a sense of shared purpose and responsibility within shared guidelines.

PCGs had to learn to apply managerial skills beyond the board to areas which had traditionally been devoid of management, to create a sense of a single organisation working towards specific goals, and to co-ordinate disparate groups into a coherent organisation. The arrangements assumed that clinician board members would be willing and able to discipline their fellow practitioners, who might well be reluctant conscripts rather than volunteers in this new enterprise (Klein, 2001). In the case of GPs in particular, this was remarkable given their independent contractor status and their opposition as a

professional group to any threats to their independence and the historical absence of co-operation between practices.

Further, there was little by way of guidance or legislation to incentivise practices to adapt to the corporate plans of the PCG, or sanction those who did not (Klein, 2001). If individual GP practices put the budgetary viability of the PCG at risk (by overspending on prescribing or referring too many patients to hospital) their colleagues had limited statutory means to bring them into line. Conversely, individual GPs had few incentives to adapt their practices to the corporate plans of the PCG. The relationship between GPs and PCG/Ts was not hierarchical: the PCG and PCT held budgets for prescribing and some general practice infrastructure, but the majority of GPs continued to hold a contract with the Department of Health, not with the PCG or PCT. A few GPs held Personal Medical Services (PMS) contracts with the PCG/T which meant they were salaried employees of the PCG/T, but this was not a powerful mechanism for managing clinical quality (Sibbald et al, 2001). This meant PCGs' and PCTs' main influence over GPs was through distributing knowledge and information and monitoring clinical practice through local professional networks (Sheaff et al, 2004).

The continuing independent contractor status of most GPs presented challenges to PCGs in the regulation of practices' spending and practices. Smith et al (2002) found that PCG/Ts had acute difficulty reaching "corporacy" or a common view. Bond & Le Grand (2003) suggest we should not find this surprising, given that many primary care actors, particularly GPs, are not used to participating in corporate decision-making. They argue that the more complex a decision is, the more likely that inconsistent and incoherent collective preferences will result. These difficulties were likely to be real, given the complexity of delivering health care.

Initially, clinical governance was defined in terms which allowed considerable local interpretation. PCGs could identify local priorities and targets. Over time, however, standards were increasingly set at national level by national service frameworks (NSFs) and the National Institute for Clinical Excellence (NICE). NSFs were documents which set minimum standards for delivery and monitoring in particular areas of care and were published for mental health (DH, 1999), coronary heart disease (DH, 2000) and diabetes (DH, 2002). NICE published evidence-based appraisals of clinical interventions and guidelines

for particular conditions such as asthma, coronary heart disease and depression (Campbell & Roland, 2003).

PCGs and PCTs were to be the guardians of clinical governance in their locality, and NHS Executive (NHSE) guidance stipulated that the PCG must ensure

> ...clear lines of responsibility and accountability for the quality of clinical care, a comprehensive programme of quality improvement systems, education and training plans, clear policies aimed at managing risk and integrated procedures for all professional groups to identify and remedy poor performance (NHSE, June 1999).

This challenged traditional and cherished medical values of autonomy and self-regulation.

PCGs were expected to implement clinical governance in two ways: first, by improving care provided by NHS organisations and clinicians by universalising often fragmented approaches such as clinical guidelines, education and training and, second, by monitoring care to ensure it met minimum standards and identifying those who do not meet these standards. PCGs were required to set out their plans for primary care development annually, in the form of their Primary Care Investment Plans.

Thus the primary care community, through their elected peers on the governing board, took on collective responsibility for the quality of local primary care services (Dowling et al, 2003). The PCG was accountable for the clinical governance of peers. Approaches to doing so included education and training, the use of incentive schemes, clinical guidelines and audit. The National Tracker Survey (Wilkin et al, 2000) found that, in general, PCGs appeared to promote developmental, supportive and educational approaches to clinical governance. Despite expressing a preference for educational approaches, clinical governance leads admitted that formal disciplinary procedures for dealing with underperforming clinicians were necessary (Campbell et al, 2002). In 2000/1 the national tracker survey found that only 7% of PCG/Ts were advocating formal disciplinary procedures, whereas by the following year this figure was up to 20% (Campbell & Roland, 2003).

Clinical governance implied a greater consistency in, and closer regulation of, working practices and service delivery. Before PCGs were established, GPs worked largely independently of one another and their practice was self-regulated. Clinical performance was assessed by other clinicians in a cursory

way with the results largely hidden from external scrutiny (Peckham & Exworthy 2003). As Campbell & Roland (2003) reflect, implementing clinical governance again meant that PCGs had to develop a more corporate culture in which quality improvement became a shared enterprise. They felt there was cause for optimism, observing substantial progress in the development of shared learning environments, sharing data and conducting cross-practice audits. However, they also found that clinical governance remained an ambiguous concept five years after its introduction, and that this had advantages and disadvantages. Its imprecise nature allowed flexibility which encouraged local ownership and locally tailored initiatives. However, over time the increasing specification, standardisation and centralisation of control (Harrison, 2002; LeGrand, 2002) may have meant that PCG/Ts came to focus on national priorities at the expense of local ones. The centralising approach was felt by clinical governance leads and managers to be at odds with the predominantly educational approaches to quality improvement being advocated by PCG/Ts. Also, a tension was identified between enabling practitioners and organisations to improve the quality of care within a supportive, no-blame environment while simultaneously monitoring care to ensure that it meets minimum standards (Campbell & Roland, 2003).

The increased scale and altered structure of the PCT had implications for the relationships of trust and sense of corporate identity on which it relied in order to implement the clinical governance agenda, and to develop a vision for the future delivery of primary care which reflected the views of its constituents. As much larger, more bureaucratic organisations, in which the influence of elected doctors and nurses was more ambiguous, it was possible that PCTs would encounter challenges to developing the shared vision that PCGs had nurtured.

3.6 Research questions and analytic framework

This section first recaps on the definition of collaboration, the main research questions (RQ1 and RQ2) and the realist theoretical framework (figure 1) set out in chapter one. It then summarises chapters two and three, drawing out the main factors relating to the first and second elements of the theoretical framework: the context in which PCGs and PCTs were introduced and their organisational forms. From these, it develops an analytical framework (figure 6) from which are derived three further research questions (RQ3 to RQ5). This

section then operationalises collaboration in ways which are appropriate to the context and objectives of the PCG and PCT and sets out the criteria by which they can be judged to be, or not to be, effective collaborative mechanisms.

3.6.1 Recap: definition, main research questions and realist theoretical framework

Chapter one defined collaboration as:

> a relationship in which two or more individuals or groups (which may be professional, occupational or organisational) adjust their behaviour in some way to pursue common goals, interests or dependencies.

This definition is sufficiently broad to accommodate the relationships required to meet PCGs' and PCTs' different remits and objectives. It frames the two main research questions for this study:

RQ1. How far did Oxford City PCG and PCT act as collaborative mechanisms to develop and deliver primary care and to improve the health of its population?

RQ2. Which factors enabled collaboration to come about, and which factors inhibited collaboration?

Chapter one also identified three interdependent elements of the examination of a collaborative mechanism which, together, form the theoretical framework (figure 1) which underpins this study.

The first element is the **context** in which a collaborative mechanism functions, in particular the driving forces which act for and against collaboration. Chapter two examined the social and political context in which PCGs and PCTs were introduced and identified the main features of the context which drove New Labour's emphasis on collaboration. This analysis of the context highlighted two broad shifts in the ethos and culture by which PCGs and PCTs would be able to meet their core responsibilities to improve the health of their population and to develop and deliver primary care services. These shifts involved the promotion of a collaborative, upstream, public health-oriented approach to health improvement, and to nurture a sense of corporacy within the primary care community.

The second is the **form** of the collaborative mechanism. This chapter has examined the structures and processes of the generic PCG and PCT and identified the key features relevant to its collaborative capacity.

The third element is the mechanism's **collaborative capacity and practice.** Chapters five, six and seven explore the implications of the context and the generic PCG and PCT form on their capacity for and practice of collaboration through the case studies of one PCG and PCT.

3.6.2 Analytical framework and further research questions

To focus these case studies, this section draws out the key features of the context and organisational form identified in chapters two and three to develop an analytic framework. On the basis of this framework it specifies three subsidiary research questions about collaborative capacity and practice which must be answered in order to address the main research questions.

Context

Chapter two identified four main driving forces for collaboration in the context into which PCGs and PCTs were introduced. The New Labour government was elected in 1997 in a political and historical context which had emerged from periods of quasi-hierarchy followed by quasi-market modes of governance. These were both judged to have been unsuccessful as mechanisms to co-ordinate the state's responsibilities, and left in their wake a number of ***complex social problems*** and ***fragmentation*** on various fronts: within primary care, between primary care and social care organisations, and between the many organisations and sectors (such as local authority departments and voluntary organisations) whose work had a bearing on health in the broadest sense and whose input was necessary to tackle complex social problems. In response to these challenges, New Labour ***distanced itself from hierarchical and network*** modes of governance by adopting a ***'third way'*** which placed great emphasis on collaboration. This resonated with a network mode of governance, centrally articulated by relationships built on trust, loyalty and reciprocity.

It also identified six forces in the context which militated against collaboration.

1. As a professional group, GPs cherished their ***autonomy***, having fought to retain a high degree of self-regulation and their independent contractor status.

2. GPs had ***little history of collaboration.***
3. GPs' professional ***status and power*** were higher than those of other professional groups such as nurses and social workers.
4. There was a history of ***animosity between doctors and health service management.***
5. Considerable ***organisational and cultural barriers*** existed between primary care and other statutory and voluntary sector bodies.
6. Further, general practice traditionally adopted a predominantly ***individualistic, medically-oriented*** perspective on health care which did not engage with the wider determinants of health and was ill-suited to addressing the causes of complex health and social problems.

Organisational form

Chapter three identified five features of PCGs' and PCTs' organisational structures and processes which were expected to equip them to facilitate, develop and promote collaboration, and to counteract the driving forces against collaboration.

1. The PCG and PCT were ***locality-wide primary care bodies.*** For the first time, a single organisational structure brought together general practices and other health and social care organisations in a locality.
2. ***Practising clinicians influenced strategy.*** GPs elected by their peers held the majority of places on the PCG's board and the PCT's PEC. Community nurses, also elected by peers, occupied a smaller numer of places. Along with non-clinical managers within the organisation, these practitioners were expected to bring first hand knowledge of local systems and need, and to be acceptable and credible to their peers.
3. The PCG's board and the PCT's PEC governing bodies provided a ***link to the local SSD*** – and potentially to the wider local authority – by including an SSD manager.
4. PCGs and PCTs were expected to devise and implement ***budgetary and clinical governance*** processes across the locality's primary care community.
5. PCGs and PCTs were charged with the local implementation of ***health improvement frameworks*** and processes such as the HImP and HIMP,

in collaboration with other local organisations. These processes to improve the health of the local population involved 'bottom-up' collaboration with a range of local organisations in identifying and addressing health inequalities.

Figure 6 shows the analytical framework which summarises the contextual forces acting on PCGs and PCTs, for and against collaboration. It also identifies the features of the organisations themselves which were expected to facilitate collaborative relationships. The parts shown in green pertain to the development and delivery of primary care, and the parts in yellow to the improvement of their population's health. On the basis of this, three further research questions are identified, which relate the third element of the realist theoretical framework: collaborative capacity and practice. These frame the analysis in chapters five, six and seven.

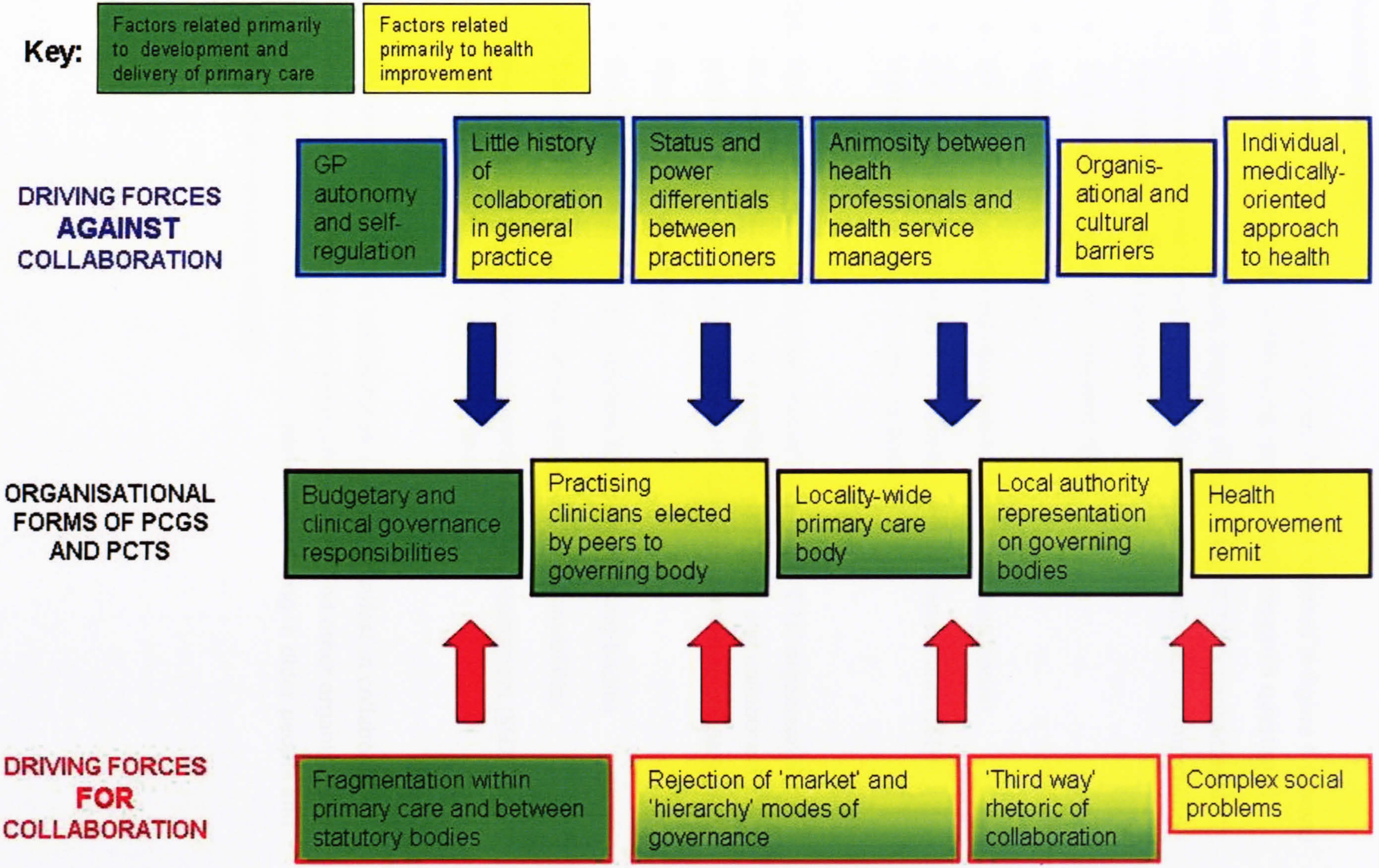

Figure 6: Analytical framework

Research questions

The analysis of context and organisational form represented in figure 6 (above) lead to the identification of the following more specific research questions.

RQ3 How far did the following features of PCGs' and PCTs' organisational forms allow them to bring about a collaborative approach to improving the health of their population?

- Their explicit health improvement remit
- Their locality-wide base
- the election of practising clinicians to their governing bodies
- the inclusion of a local authority social services department (SSD) representative on their governing bodies.

RQ4. How far did the following features of PCGs' and PCTs' organisational forms equip them to develop a sense of corporacy and collaboration within the primary care community to develop and deliver primary care?

- their locality-wide base
- the election of practising clinicians to their governing bodies
- Their new budgetary and clinical governance responsibilities
- the inclusion of a local authority social services department (SSD) representative on their governing bodies.

RQ5: Did the PCG and PCT's collaborative capacity manifest in collaborative processes and outcomes between primary care and other organisations at operational levels to promote independent living in older people and to tackle substance misuse?

Chapter four: Methods and methodology

Assessing the effectiveness of policy changes in developing collaborative primary care services and collaborative approaches to health improvement poses something of a methodological challenge. Theoretical underpinnings are contested. As much of the argument relies on the reported opinion and perceptions of participants, the subjective, situated nature of the data needs acknowledgement. Collaboration is a complex and nebulous concept which cannot be straightforwardly quantified.

I have taken a realist approach, influenced by critical realism, which is elaborated in this chapter. In making decisions about design and methods in the present research it was necessary to be iterative and mindful of the particular conceptual, practical and ethical challenges to gathering valid and high-quality data about collaboration in the context of an unfolding policy initiative.

This chapter describes how decisions were reached about the design, planning and execution of the study and gives an account of the procedures by which the data were collected and analysed. It demonstrates how these choices were informed by a realist research paradigm and its theoretical framework, and how consideration was given to issues of rigour, sensitivity and validity.

First this chapter elaborates a realist research paradigm (**section 4.1**), which has at its core a sensitivity to the contextual factors in a study. Next, in **section 4.2** the research design, a longitudinal nested case study, is described and I explain why I considered this to be the most appropriate approach to the research questions. I show how the research design was used and address its limitations. In **section 4.3** I give an account of the methodological approach, which was to employ multiple qualitative data collection methods: predominantly in-depth, semi-structured interviews conducted at two time points, supported by ongoing observation of meetings and workshops, and analysis of official documents. Next, **section 4.4** details the strengths of the in-depth semi-structured case-study method for this study: that it offers structure with flexibility and complexity. I outline how participants were selected and recruited. The strengths and limitations of the observational and documentary analysis methods are presented in **sections 4.5** and **4.6**

respectively. The ethical issues relevant to the research - in particular informed consent and assurances of anonymity and confidentiality - are examined in **section 4.7**, along with reflections on the challenges of obtaining research ethics approval for the study. **Section 4.8** accounts for the data analysis processes employed and details the approach to familiarisation, coding, thematic charting, and mapping and interpretation.

4.1 The realist research paradigm

The nature of research conducted in the social sciences, the sorts of questions that are asked and the answers that are ultimately offered, depend essentially on the philosophical approach adopted by the researcher. In the past the dominant approach to epidemiological and statistical research into health policy has been positivist and depended on measurements of such things as mortality and morbidity rates, admission, throughput and provision rates (Pollitt et al, 1990). However, the problems inherent in positivist approaches to researching contemporary policy are overwhelming. A positivist approach and the quantitative methods implied are not appropriate to answer the present research questions for several reasons. Impediments to using traditional positivist designs such as randomised controlled trials (RCTs) and quasi-experiments to research an ambiguous and conceptually elusive phenomenon such as collaboration include the impossibility of holding variables constant, the complex nature of changes to the health system, and the difficulties of isolating and attributing changes to one policy or intervention. Methodologically, positivist approaches' reliance on quantitative empirical data make them more suitable for testing tightly defined and operationalised hypotheses, than for exploring the broader questions posed in this research.

This study adopts a realist research paradigm. The epistemological underpinnings of a realist view of the social world differ from those of the positivist. The quite subtle disparity in their understandings of the nature of causation have implications for research design, data collection and analysis.

Positivism and realism share some amount of philosophical common ground, realism often being characterised (mistakenly) as a middle position somewhere between two polar extremes of positivism and constructivism. Constructivism represents a view of social enquiry based on a belief that an objective, observable, empirical reality is neither desirable nor possible as the substance

of social research, whose epistemology asserts that all that can be known about the world is human interpretation of it, and whose emphasis is often on deepening research participants' reflection upon and understanding of their own social world and experience rather than on uncovering truths or external regularities that could then be extrapolated to better understand other realities or situations. Both positivism and realism adhere to the notion that the assumptions and methods of natural science can and should be applied to social science (Smith, 1998). Both take as their objective to identify regularities according to which the social world operates, and seek to explain and predict change within it. Both positions agree that there exists an external, objective reality and hold to a deterministic epistemology. This, however, is where their similarities end, and a brief examination of the epistemological and ontological differences between the two reveals that realism is not merely a 'moderate' version of positivism or a compromise between it and constructivism, but a radical reassessment of the possibilities of social scientific enquiry.

Positivism recognises just one level of reality, the *empirical* level, at which the external world is perceived by us through our senses. Scientific enquiry, then, is based only on what is observable and the premise that there is one single objective truth. The realist, in contrast, acknowledges three levels of reality (Smith, 1998); as well as the empirical, there is the *actual* where what is observed by the senses is interpreted and given meaning in terms of cognitive structures according to language, culture and discourse. The third level can be termed the *real* at which it is recognised that objects of study in the social world are not simply passive or inert, but consist of what Pawson and Tilley (1997) refer to as 'powers', 'potentialities' and 'liabilities'; they have qualities and properties that are intrinsic to them, independent of observation or whether they are accounted for by mental constructs.

The levels of reality that each position accounts for informs their respective descriptions of the nature of causation, which is captured in the distinction drawn by Harre (1972) between successionist and generative logic. A positivist's account of causality accords with the successionist version. Causation is external to the object, which changes in a passive way as a result of some force which is intangible and can be understood only in terms of observable outcomes. Constant conjunction, or "empirical regularity," is both necessary and sufficient for a causal mechanism to be inferred.

In contrast, a realist's three-layered understanding of reality allows a generative version of causation. Causation is both a force external to the object, but also a result of its intrinsic potentialities, powers and liabilities, which can be fired, or not, by external factors. For example, a lettuce seed has various physical empirical properties such as weight, colour and DNA patterns, and can undergo changes of form that can be measured empirically. It is also associated with "meanings" for gardeners and seed retailers such as perhaps cultivation, the miracle of mother nature, a time of year or units of potential profit which must be packaged and sold. However, beyond this, and irrespective of whether its properties are observed and measured, or whether it is held amongst anyone's cognitive constructs, the seed has the "potentiality" to germinate and grow into a lettuce, given the right circumstances. Whether or not these potentialities are realised (whether or not the seed becomes lettuce) depends on the specific conditions of soil, moisture, temperature, light levels etc. Understanding causation generatively in terms of transformations of potentialities allows an appreciation of the importance of *context* to the causal relation between two events, and thus also allows room for meaningful investigation of occasions on which the two events do *not* concur.

The realist approach adopted for this study (Bhaskar, 1978) incorporates respect for scientific enquiry without being tied to a rigid and uncompromising experimental paradigm. Policy happens not in a vacuum, but in complex, sensitive and political contexts where experiences, precedents and expectations form the background (Hill, 1997). Whereas the positivist's quasi-experimental design would attempt closure to minimise the interference of extraneous variables, a realist approach to evaluation is sensitive to the contingency of outcomes on the context in which a mechanism operates. It embraces contextual variables as precisely the factors wherein the success or failure of a policy may lie. Realism holds that science only makes sense in an open setting, in the real world where policies and strategies are free to interact with the social, political, cultural, physical and economic dimensions of their environment in fullness and complexity. In attempting to iron out, or at least minimise, the contextual differences that may blur the picture of whether or not a policy works, the positivist's experimental design may remove or occlude factors that are crucial to its success. The realist is committed to building a design around a different sort of research question: one that asks not just *whether* A causes B, but *why, how and in what contexts* A is followed by B.

The approach I take in this research is influenced by the critical tradition within social science which is characterised by an explicit orientation towards a 'knowledge interest' in human emancipation rather than improving performance (Habermas, 1984). It uses critical realism as a method of studying social change by committing not only to analysing the evidence of organisational change and collaboration, but also the relationships between organisational structures and processes and their social conditions, "both the immediate conditions of their social context and the more remote conditions of institutional and social structures." (Fairclough, 1989, p 26). It aims to interrogate policy and understand the workings of society more generally.

4.2 Design: longitudinal nested case study

The first and broadest methodological question is about the overall design. How can collaboration be measured in the field? What should be measured, and how? In order to assess the impact of the PCG or PCT, the organisation must first be distinguished from the context in which it operates and then the effects of concurrent policy and organisational changes must be distinguished from the impacts of the organisation. Barnes et al (1997) make the point that objectives in public policy can be diffuse, hard to measure and subject to change during the life of a project. With this in mind, a longitudinal case study design was adopted for this research.

A case study design is recognised as a useful strategy for exploring contemporary phenomena where the issues hold complexity. According to Yin (2003: 4) it is "the method of choice when the phenomenon under study is not readily distinguishable from its context." Keen and Packwood (2000:51) see case studies as "valuable where policy change is occurring in messy real world settings and it is important to understand why such interventions succeed or fail." All of these conditions hold for this study of collaboration in relation to a PCG and PCT: the situation was highly complex; there were difficult and evolving boundary issues; and policy change was occurring in a messy, real-world situation.

The unit of analysis of a case study can be an organisation, a department within an organisation, an event or activity (such as decision-making) or even an individual person (Bryman, 1989) with the focus on its circumstances, dynamics and complexities (Bowling, 2002). This research was originally

conceived as a study of a PCG, as the transition from PCGs to PCTs was expected to come about more slowly than it in fact did. In Oxford it took place eighteen months into the study, before the fieldwork was complete so, although not a feature of the original study design, this case study was effectively based on two cases: a PCG and a PCT, and the transitional state between them.

Nested within these evolving cases were parallel, longitudinal case studies of progress on two of the PCG's five Health Improvement Plan (HImP) priorities. The HImP priorities studied were: 1) tackling substance misuse, and 2) promoting independent living in older people. These HImP priorities were selected because they exemplified contrasting issues in terms of client group, aims and outcomes of the interventions, and illustrated collaboration between different sets of organisations. A separate study focussing exclusively on HImP priorities is outside the scope of this project, but would be a rewarding exercise.

The case study method is not without limitations. The main criticisms levelled at a case study approach are connected to a perceived lack of generalisability. Generalisability is normally achieved in quantitative research by statistical sampling procedures which allow confidence in the representativeness of the sample and allow to draw inferences to be drawn about the whole population (Silverman, 2001). There is a view that results of case study research using only one or two, possibly atypical, cases cannot be generalised to wider populations, and are therefore of no value.

Some researchers claim that generalisability is not an issue because the case study itself is of intrinsic interest (e.g. Stake, 1994). Yin (1984) argues that, while quantitative research may be stronger in terms of generalisability, the purpose and strengths of the case study lie elsewhere: first, they permit the generation of theory; second, they may be employed in an exploratory manner to achieve insights into a previously uncharted area; third, they can be used to test and refine theory. Exploration, theory generation and refinement are the aims of this study.

Lewis and Richie (2003), however, draw a distinction between 'empirical' and 'theoretical' generalisation and argue that case studies *can* produce generalisable findings. Empirical generalisation applies the findings of studies to populations beyond the study's sample. Theoretical generalisation means drawing theoretical propositions from the findings of a study for wider

application, either to contribute directly to social policy or social theory more generally. This research aims to achieve theoretical generalisation through offering inferences of relevance to social policy on collaboration, and through inductive data analytic processes which contribute to the wider theoretical debate about the relationships between contexts, forms and capacities of collaborative arrangements covered in Chapter 2.

The advantages of the design of this study are that it affords the depth of a longitudinal case study which captures comparisons. In the study we are able to compare the two organisations: the PCG and the PCT that evolved from it and we are able to compare two more specific areas of work (substance misuse and promoting independence in older people).

This enhances the richness of the theory generation and the potential theoretical generalisability of the findings. Its longitudinal design allows an exploration of the interactions between the driving forces for collaboration, the local context and the organisational forms of the PCG and PCT. This facilitates a micro-level examination of the complex forces which, over time, influence the capacity for, and practice of, collaboration in these specific cases.

4.3 Methodological approach: multiple qualitative data

Snape and Spencer (2003) align themselves with pragmatists - more interested in achieving a suitable "fit" between the research methods used and the research questions posed than in the degree of philosophical coherence of the epistemological positions typically associated with different research methods. A realist paradigm does not tie a researcher to any particular methodological approach, but can underpin any combination of methods depending on the nature of the research question and the stage of development of hypotheses.

With a realist approach, quality and rigour have more to do with choosing the right tools for the job than with limiting ourselves to combining only those research methods which are viewed as philosophically consistent. Quality and rigour depend also on revealing the different ways in which each method, tool or approach contributes to an understanding of the research question.

Methods and methodologies are more or less useful depending on their fit with the theories being developed or tested, and the research topic that is selected. The crucial questions in the choice of research methods surround the nature of

the information that the research needs to provide. The present research aimed to explore and refine hypotheses rather than testing tightly operationalised, falsifiable ones. Case studies are generally (but not exclusively) associated with a qualitative approach. Qualitative methods are most appropriate when the phenomena being studied are ill-defined or not well understood, and refinement of understanding is needed. The open and generative nature of qualitative methods allows the exploration of complex issues as a basis for further thinking about policy or theory development.

> Qualitative methods are more likely to identify the cultural and behavioural issues so important to the changing health service environment... Development of corporacy, ownership, multidisciplinary ethos: all are necessary precursors of service change, shifts that have only been noted and their value realised through adopting less medically-centred, more sociologically derived evaluation methods. (Shapiro, 2001: 22)

Qualitative methods were adopted for this study because of the complex and multi-faceted nature of collaboration. Multiple qualitative methods were employed: semi-structured interviews were conducted at two time points, supported by ongoing ethnographic observation of meetings and workshops and analysis of documents to investigate fully complex situations[3]. They allowed detailed and rich data to be collected using some techniques which involved close contact between the researcher and the participants and others which drew on different sources of information. Together, these allowed the exploration of emergent issues (Silverman, 2001) and some validation the findings (Bowling, 2002).

---

[3] See discussion in section 2.8 about boundary-spanners and trust

4.4 Interviews: strengths of the in-depth semi-structured case-study method

Ritchie (2003) distinguishes naturally occurring data from generated data. Generated data include biographical methods, focus groups and in-depth interviews. They involve reconstruction (Bryman, 2001) and require re-processing and re-telling of attitudes, beliefs, behaviour or other phenomena. The experience, thought, event or whatever, is mentally re-processed and verbally recounted by study participants. Generated data give insight into people's own perspectives on and interpretation of their beliefs and behaviours and, most crucially, an understanding of the meaning that they attach to them. They provide the only means of understanding certain psychological phenomena, such as motivations, beliefs, decision processes and also because they allow participants' reflections on, and understanding of, social phenomena to be gained.

Interviews provide an opportunity for detailed investigation of participants' personal perspectives. They are well suited to research that requires an understanding of responses to complex systems, processes or experiences because of the depth of focus and the opportunity for clarification and detailed understanding. They allow insight into their perspectives on their behaviours and beliefs, motivations and decision processes. Participants may reflect both on the issue in question itself and on their own thinking and facilitative questioning may help them in the process. (Snape & Spencer, 2003). Below I discuss the recruitment of interview participants, the interview procedure, and how some of their features came into play in this research.

4.4.1 Structure and flexibility

The in-depth interview is intended to combine structure with flexibility. Generally, the structure takes the form of an interview schedule which sets out the key topics and issues to be explored. However, it incorporates sufficient flexibility to allow the researcher to respond to and explore issues raised by the interviewee, and to do this in the order most suited to the interviewee.

For this study, the interview schedule outlined the main topics to be covered according to what was relevant to each participant on the basis of their role or position in an organisation. A decision was taken to send an outline interview schedule to participants in advance of the interview. The rationale behind this was twofold: First, it would allow the interviewee time to consider the areas to be covered before the interview with the possibility that this would lead to a more considered discussion of the issues. Second, when trying to recruit participants on the telephone, misgivings were frequently expressed by the potential interviewee about whether they would be able to contribute usefully to what appeared to some to be a rather abstract research question. It was considered that an advance sighting of the interview schedule would serve either to reassure the participant that they would be able to contribute to the research, or to confirm their doubts so they could decline to be interviewed. Lewis & Ritchie (2003) warn that giving too much detail may deter potential participants. In this study, nobody withdrew their offer to take part after seeing the interview schedule, and sending it in advance appeared to allay people's concerns.

Other potential disadvantages of sending an outline interview schedule in advance were considered. Lewis & Ritchie (2003) also warn that it may curtail participants' spontaneous views by being over-specific about the objectives and subject matter. It could have enabled participants to prepare a sanitised account of a more messy reality, or to prepare grievances they wished to air. Measures were taken to minimise these negative effects. Rather than sending a list of questions, the outline schedules were typically arranged into two or three broad areas for discussion with three or four bullet points under each, so as not to encourage respondents to run off completely prepared responses and to allow responsiveness. It was considered that the potential loss of spontaneity did not pose a substantial danger in this research since the aim was not to gather intuitive reactions. It was judged that the risk that this strategy would yield more contrived data was outweighed by the benefits.

In general, discussion focussed on people's perceptions of the PCG's impact on collaborative activity. For example, what collaborative working happened before the PCG or PCT was in place and how had that changed? What structures were in place to facilitate joint working, and which of these could be judged to be a result of the PCG or PCT? How might individuals have managed a problem

or issue relating to collaboration before the PCG was in place? Has a new PCG structure helped or hindered a piece of collaborative working?

The interview schedules were tailored to the profession or position of the individual participant and the stage of iterative data analysis. For example, an early interview with a PCG board member would have included general questions about the nature of inter-professional collaboration within the board, and the potential to collaborate with organisations from outside of the NHS. An interview carried out at the second data collection point with a PCT manager whose remit related specifically to health improvement would have been informed by previous knowledge about the work of the PCG and the recent history of health improvement work locally. It would have asked specific questions about, say, the influence of targets issued by central government in the *NHS Plan* on the nature of the PCT's work towards reducing inequalities in health, and how this compared to the approach taken by the PCG when targets were locally determined through the HImP process.

This illustrates how data analysis and collection are not distinct activities but inform one another. A point made in one interview would be followed up in a later interview; similarly, themes emerging from documents or during observation of meetings would be introduced to an interview.

4.4.2 Depth

There is considerable variety in the perspectives on in-depth interviewing which stem from differences in views on a) how structured they should be, b) in how far the content is set by the researcher or participant and c) how far knowledge is constructed in the interview or is a pre-existing phenomenon (Legard et al, 2003).

Through the use of probes, and the ongoing rapport between researcher and interviewee, interviews were able to achieve a depth of data that would not have been obtainable through, say, questionnaire research. I had the opportunity to explore the reasons, feelings, opinions and beliefs that underpinned participants' answers (Legard et al, 2003). To some extent, the interviews were generative in the sense that participants explored issues in ways they previously had not, creating new knowledge or thoughts. They were also prompted to propose solutions to problems raised in the interviews.

Carrying out these interviews successfully rested on the establishment of good rapport with a range of participants from powerful chief executives to vulnerable older hip fracture patients. Central to this rapport was creating an environment of trust in which it was clear that I was genuinely interested in the perspective of the participant, could show understanding and empathy, and was credible.

Credibility depended on both familiarity with the participants' organisations and thorough pre-interview preparation that allowed me to develop questions which were seen as meaningful by the participants and which demonstrated an understanding of the issues around local organisations, the role and work of each participant, and around collaboration more generally. My ongoing presence as an observer in PCG and PCT meetings – attending approximately 90 percent of the PCG public board meetings and two thirds of the PCT board meetings, as well as many of the subgroup meetings – meant that I was not viewed as a complete outsider, and seemed to contribute to my credibility with participants.

The interviews with health and social care professionals and independent sector employees were arranged for a time and a place to suit the interviewees, usually at their place of work if they had access to a suitable room which was quiet and offered sufficient privacy. Conducting interviews on participants' own territory was designed to make them feel at ease and relaxed. It also meant they did not need to travel to the interview, thus removing another barrier to their agreement to participate. Where this was not an option, the interview was conducted at my University office. When several members of one organisation, usually a general practice, were to be interviewed, efforts were made to arrange them on the same day to minimise the time I spent travelling.

At the beginning of each interview, the aims of the research and the purpose of the interview were restated and participants were invited to ask any questions before they signed a consent form. Permission was asked to tape record the interview. They were also involved in the decision about how any quotes from their interview would be attributed (see 'ethical considerations').

The interview process itself requires considerable concentration on the part of the researcher, who must simultaneously listen to what the participant said, exercise judgement about what probes were appropriate, consider how they related to what the participant had said previously as well as what other participants might have said, and formulate the next question. Occasionally

noting down key points from what the participant said to return to later in the interview was helpful, though it was important not to do this to the point that it interrupted the flow of the interview or gave the impression that I was not paying careful attention to what the participant said.

Once the interview itself was finished, the interviewee was asked if there was anything they would like to add or ask on tape. The act of switching off the tape recorder often prompted some new and interesting information from the participants. Where it seemed significant, then I would ask if I might set the tape recorder running again, or make notes which could be used with the same assurances of confidentiality and anonymity as the transcript. Usually the participant agreed to this, but if they did not, the data could not be used.

4.4.3 Participants

Oxford City PCG was originally chosen as the unit of analysis for the case study for pragmatic reasons: it was local and the chief executive was co-operative and prepared to facilitate access to meetings and staff. The participants within the study were chosen more purposively.

The research questions guided the construction of the interview sampling frame. The sampling strategy was purposive, as this study was not designed to allow empirical generalisation from sample to population or statistical significance testing. Rather, a theoretical sample was employed in which, in the words of Boulton & Fitzpatrick,

> on the basis of his or her theoretical understanding the investigator determines what factors might affect variability in the observations and then endeavours to draw the sample in a way which maximises the variability. (1994: 111)

Consideration of the responsibilities and remits of the PCG and PCT guided the selection of interview participants. Two of PCGs' and PCTs' main remits were the development and delivery of primary care and the improvement of their population's health. These two areas of work had quite different objectives, and so the collaboration called for in each case would be expected to differ in terms of a) the groups between which collaboration was required and b) the goals and interests in pursuit of which they collaborated. Figure 5 shows how this guided the selection of participants and, simultaneously, the early stages of construction of interview schedules.

	Health improvement	Development and delivery of primary care
Collaborating groups	• primary care • local authority • voluntary sector organisations	• different professional and managerial groups within primary care • PCG and the primary care clinicians in the community and in general practice
Goals and interests	• improvement of health in broadest sense in locally defined ways • identification and tackling of health inequalities • emphasis on prevention and health promotion, as well as medicine.	• improvement of delivery of primary care services • development and implementation of clinical governance and budgetary strategy

Figure 7: Factors which guided selection of participants

The original sample was designed to include representatives from different levels of the organisations being studied: the PCG and PCT themselves, local authority, primary health care teams (PHCTs) and some voluntary sector organisations. Participants from this range of settings were identified as relevant by their job title, role, or through recommendation by another informant. The process of devising a matrix of organisations and levels within them then of filling it with participants' names was done in consultation with key local figures who had an overview of one or more of these organisations. They were able to point towards the appropriate individual or to someone who would be able to suggest a key contact.

Inevitably there was something of an 'implementation gap' between the original tidy wish-list of interviewees and the inventory of people who were

subsequently interviewed. Over the course of the study the sample was adjusted as the PCG expanded and became a PCT, as staff turnover and restructuring inevitably affected the key representatives from other organisations. Opportunistic sampling took place as new staff were appointed to the PCG or PCT, or became regular attenders at sub-group meetings, or were mentioned frequently and significantly in interviews. This was most often the case with voluntary organisations and 'one off' health professionals such as the domiciliary physiotherapist, from organisations without statutory representation on the board or PEC. While the sample could not be exhaustive, the advantages of this combined approach to sampling were that, within the obviously key organisations, representatives of various levels of seniority were systematically included, while opportunistic sampling permitted the inclusion of those less obviously relevant at the outset.

Unsurprisingly, a number of people declined to be involved in the research. The reason offered most often was pressure of time. The thirty-two PHCTs in the city were researched carefully in terms of list size, number of partners, geographical location, previous fundholding status and inclusion or exclusion from City Council boundaries. Eight of these were chosen, constituting an ideal purposive sample. However, the process of recruitment revealed that a significant proportion of the sample was less motivated to preserve the original sampling strategy than its author. This was largely because they were being asked to give of their most prized commodity - time - with scant promise of tangible short-term reward. In some practices, receptionists and practice managers were extremely co-operative and helpful, whereas in others they proved to be formidable and at times intransigent gatekeepers. Smart challenges the usual assumptions about the direction of power imbalances between interviewer and interviewee: "To assume the power imbalance is inevitably in favour of the interviewer is to ignore all other social class divisions and structures of dominance in society outside the academic world of research" (1984: 157).

This resonated with my experiences of trying to recruit busy senior health service professionals to contribute to my research. Ultimately they could decline to take part, and some did. The achieved sample of five PHCTs was ultimately as opportunistic as purposive. Fortuitously, the criteria by which the original sample was selected were still broadly met, although it may be skewed

in favour of unrepresentatively research-friendly practices, or practices with a greater-than-average level of interest in the research areas.

4.4.4 Recruitment

Professionals/ staff

The methods of recruitment varied depending on the role or positions of the individual participant. Recruitment generally happened in two stages and was consistently time-consuming. The first stage was to establish contact and stimulate interest in the project. It typically began with an introductory telephone call briefly to outline the purpose of the research, how the participant was selected, what taking part would involve and to suggest I send them some written information. If they express willingness to consider taking part, the phone call was followed by a letter reiterating this information more fully (see Appendix 1) and saying they should expect a phone call, during which there would be an opportunity to ask questions about the research and, if they would like to take part, to arrange a time and venue for the interview. This call constituted the second stage during which assurances of confidentially were given, and permission was requested to tape record the interview. Once a time had been agreed, it was confirmed in a letter which was sent out with an outline interview schedule, an information sheet and a consent form which they were asked to bring with them to the interview (See Appendices 2,3,and 4).

The recruitment strategy for PHCT members was slightly different in that practices were initially approached through the practice manager who was asked to distribute information about the project to the practice staff then, at a practice meeting, enlist a GP, a district nurse, health visitor, practice nurse, and receptionist who would be willing to take part. Once practice staff who were prepared to take part in the study were identified, a telephone call confirmed the date, time and venue of the interview, and a letter was sent to each with an interview schedule, information sheet and consent form.

Although this recruitment procedure was cumbersome, it was ethically and pragmatically better to invest the time in explaining to potential participants what the research was about, rather than risk their feeling pressured to volunteer their time to take part in something they didn't yet understand or recognise as worthwhile or relevant.

Interviews were conducted over two time periods. The first set took place in the spring and summer of 2000, when the PCG was still in place but the transition to PCT was imminent.

In the first set of interviews, nine GPs (two were board members, including the chair), eight community nurses (one were board members), three City Council staff and four SSD staff (these did not include the SSD board representative who was not available to be interviewed), five non-clinician PCG staff and board members and two participant from non-statutory bodies (Age Concern and the Carers' Centre) were interviewed. Additionally, a community development nurse from the Community Health Trust, the Health Authority's Joint Investment Plan co-ordinator, and four other community therapists. A full list of the participants is in Appendix 5.

The second set of interviews took place approximately one year later, following the transition to PCT. This was a period of great upheaval, but where a participant from the first set of interviews remained in the same, or equivalent, post, they were approached and invited to take part in a follow-up interview. Many of the organisations involved, particularly the PCG, underwent dramatic organisational upheaval and structural change, so not only were the same individuals difficult to trace, often their posts no longer existed, neither was a successor available. Arranging the follow-up interviews was much more straightforward where the same individual was in post, not least because there was a sense of camaraderie amongst those who survived the transitions, in which I shared. Where new people or posts were in place, the process of explaining the research and recruiting them to it began anew.

The second set of interviews was smaller and included the PCT chief executive, two GPs (including the PEC chair), four community nurses (one was a board member), three non-clinical PCT staff and two local authority staff: one from the City Council and one from the SSD.

Service users

The study originally sought to identify the impact of the PCG and PCT on collaboration from the perspective of service users as a measure of the outcome of collaboration. Interviews with older people were to provide contextual data which would allow the accounts of older people to be compared with those of the health professionals, and to explore the extent to which changes in service delivery and collaboration were actually experienced

by the users. After all, collaboration should not be an end in itself, but a means to improving the experiences of patients. Time and resource limitations meant that interviewing a sample of older people as well as a sample of drug users was not possible, so a choice had to be made between the two groups. The experiences of either group would have been interesting to study, but older people were chosen on the basis that, if a sample of hip fracture patients was taken, they would be easily accessible on the hospital ward. Methodological impediments to interviewing drug users include issues to do with access, engagement and trust. The sample of older people was narrowed to older people who had had a hip fracture, since they were likely to be in receipt of care from a range of professional groups and organisations including primary care, secondary care, social services and voluntary organisations. Their common condition would mean that their service needs were likely to be comparable to some extent, while diversity in their individual circumstances would mean some variation in their experiences and needs. The limitations of choosing this particular group is that their experiences would, in many ways, be peculiar to one condition. However, hip fracture is a common condition, and a serious one in that readmission to hospital and mortality rates are high.

It was planned that semi-structured interviews would be conducted to explore the experiences of people who had returned home following a hip fracture, to provide contextual data to corroborate (or not) the accounts of health and social care professionals. People over the age of 65 who had had a hip fracture and who were registered with a GP from within the PCG constituency were to be accessed through the trauma department at the local general acute hospital. Patients whose first language was not English or who were judged by the researcher or their primary nurse to be too cognitively impaired to take part were to be excluded from the sample.

Although approval was obtained from the local NHS research ethics committee, the conditions which were imposed on obtaining consent from hip fracture patients were so stringent as to be prohibitive. The lengths to which potential participants had to go to demonstrate their non-coerced consent included having to actively return a consent form to the researcher, which was prohibitively difficult given their frail and vulnerable condition. This undoubtedly contributed to difficulties recruiting older people to the study, and caused a large amount of fruitless labour for the researcher visiting the trauma wards repeatedly. Lower than expected numbers of patients fitted the

inclusion criteria, and there was a reluctance amongst those who did qualify to take part. The minority who volunteered tended to be the least vulnerable and frail, unlikely to have a social services care package and therefore not well placed to describe their experiences of co-ordinated care.

Even having found a willing gatekeeper on the ward, recruitment was unsuccessful, yielding only four interviews over a space of four months. Ultimately, a decision was taken to abandon efforts to include older people's perspectives of care in the study. Three interviews were carried out, but the contribution they could make to the study was too limited to include.

4.5 Observations: strengths and limitations of observing meetings

Non-participant observation of meetings and workshops of the PCG and PCT's was ongoing throughout the period of the study. Observation as a method has its own challenges. These include gaining access, observer bias and the reactive effects of the observer's presence.

I attended almost all the PCG and PCT board meetings over the period of the study as well as many of their sub-group meetings. Watching, listening and note-taking allowed me to gather qualitative data of a different sort. While interviews provided valuable insights into participants' thoughts, motivations, perceptions and reasoning, data obtained in this way were generated by the participant, and their construction was mediated by the participant's memory, world view, life experiences, political leanings, etc, and produced in a somewhat artificial interview context.

Snape & Spencer (2003) distinguish these generated data from naturally occurring data. Naturally occurring data are obtained by investigating phenomena in their natural settings. Observation data are an *enactment* of social behaviour in its own social setting, rather than a *recounting* of it generated specifically for the research study. Collaboration was so fiercely rhetorically invoked in the policy environment to the point that it adopted an almost moral dimension. Participants' reports of it were, therefore, prone to distortion as social forces were liable to influence them, consciously or unconsciously, to exaggerate accounts of their collaborative activity. Observation of meetings could provide some balance to this as they allowed

first-hand scrutiny of interactions between participants at meetings. It allowed events, actions and experiences to be seen through the eyes of the researcher without any construction on the part of the participants.

Complementing interviews with PCG and PCT board members and staff with observations of their behaviours, actions, activities and interactions provided a tool for understanding more than what they said about the organisations and their collaborative activities. This allowed me to place data from interviews in a more rounded context, to interpret inconsistencies between them, and to understand the complex situations more fully.

4.5.1 Gaining access

Bowling, (2002) warns that gaining access to the desired setting is potentially a problematic area due to people's suspicions about academics and their motives, as well as feelings of personal and professional threat. Time must be spent forging links with the community of interest before access can be expected, and explanations should be offered about how the study can be mutually advantageous (Hornsby-Smith, 1993).

In this study, access posed fewer difficulties. PCG and PCT board meetings were open to the public and were held every two months. I was initially given access to other PCG meetings through negotiations with the PCG chief executive who was supportive of the research and acted as a co-operative gatekeeper. His endorsement of the project afforded access to sub-group meetings which were not open to the public, and meant I was generally not viewed with too much suspicion. Still, some effort was required to strike up rapport with the various groups, and to learn their language, concepts and practices (Pope et al, 2000b).

Some meetings remained out of bounds. For example, I was not granted access to workshops at which the PCG board met monthly, between the public board meetings. These were designed in part to facilitate development of the board, and they decided that the presence of a researcher might stifle openness and the board members' interactions.

4.5.2 Observer bias

While observation is not mediated by the generation of a narrative by the participant, it is nonetheless open to observer bias. This is defined by Bowling

as a systematic difference between a true situation and that observed owing to observer variation in perceptions (Bowling, 2002). She contests that efforts should be made to reduce the tendency to report interpreted (perceived and inferred) events, rather than the events themselves. My view is that data gathered through observation are inevitably and necessarily dependent on the observer's interpretation. While a degree of reflexivity on the part of the researcher can minimise the effect of this interpretation on the analysis of the data, it would be misguided to strive for full objectivity in an observer's account, untainted by interpretation or bias. Rather, efforts were made to reflect on the likely nature of this bias and the limitations it places on the validity of the findings.

4.5.3 Reactive effects of observer's presence

Data gathered through participant observation are subject to the effect of the researcher's presence in the room. Roethlisberger and Dickson (1939) termed this the Hawthorne effect: people change in some way simply as a result of being studied. The effect of the observer appears to erode over time (Clarke & Bowling, 1990); thus it is sometimes argued that the analysis of observation data should commence after a time period when the reactive effects of the observer have worn off. However well integrated the observer becomes within the setting, there is always potential for a reactive effect and therefore bias. It is important that the observer maintains an awareness of this (Bowling, 2002). Factors which minimised the Hawthorne effect in the observation in this study were twofold. First, towards the beginning of the fieldwork period, the PCG was new and the participants' relationship with a researcher was one of many new relationships being established at that time, and one of the least salient. Its impact was therefore diluted. Second, the rapid expansion of the organisation in its early days, and the rate of staff turnover at the point of transition from PCG to PCT meant that, before long, I was one of the longest-standing attendees at many of the meetings, and familiarity seemed to reduce awkwardness and mistrust resulting from my presence.

4.6 Documentary analysis

Documentary analysis of agendas, notes and minutes from board and sub-group meetings, notes from consultation days and a HImP development

workshop provided evidence as to which organisations were represented and at what level. This was supplementary to the observational and interview data. They showed who had committed to do what and with whom. They could also evidence the development of structures to enable joint working, for example, joint appointments, Joint Investment Plans, and the HImP group's wide membership. These complemented the interviews well as sources of information about who attended partnership events, and to some extent, what they contributed, but told little about the subtleties of the development of trust between organisations and other less tangible phenomena.

4.7 Ethics

4.7.1 Research Ethics Committee approval

The principles underpinning research ethics are beneficence and duty of care, informed consent and confidentiality. Research ethics committees were established in response to grossly unethical practices involving human experimentation in medical and social sciences research, to protect participants from harm. They have a duty to consider all possible sources of harm – particularly to vulnerable participants – and to satisfy themselves that the researcher has thought through all relevant issues before they proceed (Darlington & Scott, 2002). My experience of applying for approval from the local NHS Applied and Qualitative Research Ethics Committee for this study, suggested that a system designed to protect patients and other participants from harm could in fact be obstructive of research designed to give voice to vulnerable people, effectively further disenfranchising them. The conditions which were imposed on obtaining consent from hip fracture patients were, in the end, so stringent as to be prohibitive.

4.7.2 Informed Consent

Interviews

Informed consent means giving information about the research which is relevant to the participants' decisions about whether to participate; making sure that subjects understand that information (for example, by providing information sheets written in their language) and ensuring that participation is voluntary (for example, by stating very clearly that the decision whether or not

to participate will not have consequences for the care a participant receives, and requiring written consent) (Silverman, 2000).

An information sheet (see Appendix 3) told participants about the purpose of the study, how the data would be used, and what participation would require of them. The sheet listed the subjects likely to be covered and how much time was required. Having read it, they were asked to sign a consent form (see Appendix 4), stating that they had read and understood the information sheet, that they understood issues to do with confidentiality and anonymity, and that they had had an opportunity to ask questions. Even once a person had consented to take part in an interview and to the data being used in the way that has been described to them, I was mindful that consent is not absolute, and should be assessed and sometimes renegotiated. This was particularly true at times during data collection when an interviewee would divulge information or opinion which, if reported, may have undesirable repercussions. This occurred only a few times, but when it did, the way the data would be used was discussed again with the participant.

Observation

Informed consent was less easy to obtain in observation than in interview situations. I was initially given access via the PCG chief executive, a powerful gatekeeper, to most PCG meetings, but I was not able to obtain the full explicit consent of each person at each of the meetings. Where the opportunity arose, I said briefly who I was and what the research was about, but the quick round-the-table introductions which happened at the beginning of most meetings did not afford time to explain in detail who I was, what I was doing, why and to check that everyone had understood and consented to my presence. If anyone had objected, I would have left, but it might have felt quite difficult for anyone to do so. Certainly towards the end of the study, I was almost an integrated part of a number of groups, and regular members seemed barely aware that I was not a member of the group.

4.7.3 Anonymity and confidentiality

Beyond this, the ethical considerations relevant to this study could be said to fall into two broad categories: remaining sensitive to issues of confidentiality and anonymity, and further issues around the dissemination of what were sometimes quite sensitive data.

Anonymity implies that the identity of those taking part is not known beyond the research team. This may be compromised if participation is arranged through a third party (an employer or an organisation) or in case studies (Ritchie and Lewis, 2003). Confidentiality means avoiding the attribution of comments, in reports or presentations, to identified participants. Both direct attribution (where comments are linked to a name or a specific role) and indirect (by reference to a collection of characteristics that might identify an individual or small group) must be avoided. Indirect attribution requires particular care. It may compromise the extent to which contextual detail can be given in reporting specific comments and in some circumstances it may be necessary to change minor details to disguise identity, to make a point in a more general way (even if this reduces its power), or to get specific consent from a participant to use it (Ritchie and Lewis, 2003)

In a relatively close-knit social and health care community such as Oxford, not attaching interviewees' names to quotes does not necessarily guarantee anonymity. An example of this can be seen in reporting quotes from the board nurses. The PCG board included three nurses who, if they were referred to in a report as 'board nurse,' would be quite identifiable to any reader familiar with the Oxford primary care community. The identity of the contributor could be narrowed down from three to one with reasonable confidence from the language they use, their ideas, and the context of what was said. An alternative would be to attribute the quote simply to 'health visitor 3,' or 'Community Nurse 16,' which would further protect anonymity (since there are many community nurses in the city, and only three board nurses) but would impoverish the data, in that richness would be lost with the information that this was the view or experience of a board member. There was a trade-off between the anonymity to be gained from being very vague in the description, and the greater richness of data associated with being able to match an individual's views or experience closely with their role.

The approach taken was to allow participants to participate in the decision. At the beginning of each interview, the interviewee was asked how they would like their quotes to be attributed. The option was offered to leave this judgement at the end of the interview, at which point the participant would be better informed as to the content of the interview. Some were content to be described quite specifically (e.g. Health Promotion Officer), while others preferred to be identified only loosely (e.g. Community Health Trust employee). The assurance

was made that they would be contacted for clearance before anything was published which was considered by the researcher to be contentious from their interview.

4.8 Data analysis

Analysis is the process of describing the data, categorising them and examining how concepts interrelate (Dey, 1993), confirming, refuting or refining theories (Pawson & Tilley, 1997) and developing further theories. Here, the principles and procedures applied in analysing the data in the present research are made explicit.

Ritchie and Spencer's (1994) 'framework' strategy guided the data analysis. It was devised specifically for the analysis of data in applied qualitative policy research, and its strengths as an approach are that it is explicit, accessible, systematic and comprehensive. The specific stages of data analysis are described later in this chapter, but first the approach to the data is described.

Although there will be a stage of the research dedicated to data analysis, the process of forming ideas, identifying concepts and testing theories continues from beginning to the writing up of a study (Spencer et al, 2003). To some extent data collection and analysis were carried out simultaneously as the data gathered fed into and informed the ongoing data collection (Mays & Pope, 2000).

Qualitative data are usually analysed in a way that is open to emerging concepts, provide detailed description, and identify patterns of association, but approaches to analysis differ in terms of the main focus and aims.

4.8.1 Inductive vs deductive

A distinction is often drawn between inductive and deductive analysis. Deductive analysis, or theory-testing, either confirms or refutes a particular defined and falsifiable hypothesis. The investigator starts with general ideas and develops a theory and testable hypotheses from it, which are tested by gathering and analysing data (Bowling, 2002). Inductive analysis, on the other hand, involves theory-building: the extraction of themes and theories from the data themselves. It begins with the observations and builds up ideas and more general statements and theories (Bowling, 2002). It looks for patterns and

associations derived from observations of the world (Snape & Spencer, 2003). It aims to identify deterministic laws and the essential character of phenomena, involving an iterative process of defining a problem, formulating and testing an hypothesis, then reformulating the hypothesis or redefining the problem until all cases "fit" the hypothesis (Robinson, 1951)

Dey's (1993) approach is to dispense with the distinction between inductive and deductive analysis, since data cannot be analysed without ideas, but ideas must be shaped and tested by the data. Bowling concurs that, in practice, science is based on a more haphazard blend of the rules of deductive and inductive reasoning. "It is a mixture of empirical conception and the certainties of deductive reasoning" (Bowling, 2002: 122). Both deduction and induction are involved at different stages of the qualitative research process. While inductive processes use evidence as the genesis of a conclusion, deductive processes use evidence in support of a conclusion (Snape & Spencer, 2003)

The status of the explanations that are offered in qualitative analysis varies. The aim of analytic induction is to seek explanations in terms of universal deterministic causes. Others reject this, and argue that the social world is not governed by laws in the way that the physical world is thought to be. However, if human behaviour is not law-like, neither is it chaotic; it displays regularities which can be identified through careful analysis.

The realist approach, as outlined by Pawson & Tilley (1997), is to test theories about the interactions between context and intervention or policy. These are not necessarily grand theories of the universe; depending on the stage of theory development of the research, they can be all-encompassing or quite humble in their scope. The realist approach contends that all data collection should be theory-led, but acknowledges a broad variety of theories. Section 4.5 and figure 5 illustrated how theory influenced the selection of research participants and the early stages of designing the interview schedules. A theory need not be a positivist-style falsifiable one, operationalised in such a way that it can be shown to be either supported or rejected by the data (although it may be). It could equally be a less tightly operationalised theory, which can be refined through the data analysis process in conjunction with an iterative data collection-analysis process.

The aim of this research was to develop and modify theories in this way. The literature covered in chapters two and three identified preliminary theories about the organisational forms of the PCG and PCT and the contextual factors

acting on them in ways which might enhance or inhibit their collaborative capacity. Figure 6 summarises/represents the preliminary theories which informed the early data collection and formed the basis of the deductive analysis.

The data analysis adopted a combined approach in which both *a priori* and emergent concepts were used to shape the analysis. Spencer et al (2003) describe an "analytic hierarchy" which sets out a non-linear progression through levels of analysis from data management, through descriptive accounts to explanatory accounts. The analytic account is refined by movement in both directions between data and analytic concepts.

For example, PCGs' and PCTs' locality-wide reach and the election to their governing bodies of practising clinicians implied potential as mechanisms to facilitate collaboration within the primary care community to develop and deliver services. The problems associated with the fragmentation within primary care, together with New Labour's third way rhetoric, were identified as contextual forces which could act to drive collaboration. On the other hand, it was proposed that GPs' tradition of autonomy and self-regulation, and the scant history of collaboration within general practice, however, might act to inhibit collaboration.

Theories based on these contextual and organisational factors, and others identified in figure 6, formed the basis of the deductive approach which informed the early data collection, guided the selection of interview participants and the construction of the interview schedules. Inductive elements contributed to the evolution of the theories over the course of the study to reflect early findings, ongoing organisational change and the publication of new guidance and policy. The aim of the research was not to prove or disprove these theories, but to combine deductive and inductive elements, to test theories iteratively against the data, refine them on the basis of the degree to which they were found to fit, or not, and so on.

4.8.2 Evaluating collaboration

It is important to specify criteria for the effectiveness of a collaborative mechanism in ways which are appropriate to the context and objectives of the PCG and PCT, against which its performance can be assessed. This section draws heavily on the ideas of Dowling et al (2004) who distinguish between evaluations of the processes and outcomes of collaboration, i.e. evaluations of

how a collaborative mechanism itself *functions* and of its *products* (Lazenbatt et al, 2001). Collaboration should not be an end in itself, but Dowling et al's (2004) literature review found the majority of published research on successful partnership working had largely focussed on process rather than outcome measures. They argue that this focus has limited the knowledge of whether collaboration 'works' in the sense of bringing benefits from a service user perspective which should be, after all, the ultimate policy goal of collaboration.

This study set out to assess both processes and outcomes of collaboration, with a focus on the collaborative capacity of individuals and organisations, as well as on whether collaboration led to improved services and service user experiences. However, for reasons set out in section 4.4, the planned inclusion of service users as participants in the research became unfeasible. So the focus was turned to process issues about the 'health' of collaborative relationships and outcome issues about service development.

Process and outcome evaluations

Health improvement - process

Evidence of successful collaborative processes for health improvement was sought by examining whether and how primary care worked with organisations outside of the NHS such as local authority departments and voluntary sector organisations. Given general practices' sparse history of collaboration, and the organisational and cultural barriers to collaboration between these groups, as well as status and power differentials between them, and the tradition of animosity between health professionals and health service managers, effective health improvement processes would manifest in any sign of commitment and engagement of these groups to working together, and evidence of trust, reciprocity and respect. Boundary-spanner activity would also signal collaborative processes.

In the context of GPs' traditionally medically-oriented, individual-focussed approach to health and the emphasis of PCGs' and PCTs' remit for the improvement of health through addressing wider, non-medical determinants of health (for example social, environmental and economic factors), evidence of agreement about the purpose and need for collaboration would also signal process success. This may manifest in evidence that such an approach to health was a vision shared between primary care, local authority and voluntary sector organisations.

Health improvement – outcome

Evidence of outcome success in health improvement was more difficult to identify, since by their nature the health outcomes of health improvement work are often long term, and can not easily be attributed to a single intervention. They were sought in the development of services or projects to address priorities set out in the PCG's and PCT's health improvement frameworks such as services to promote independent living in older people.

Primary care development/delivery – process

Successful collaborative processes for delivering and developing primary care would manifest in processes which facilitated collective efforts to develop and implement clinical governance and strategies for the allocation of the organisations' substantial budget, and which were inclusive of a range of primary care professionals.

In the context of the fragmentation of primary care and GPs' tradition of autonomy and high degree of self-regulation, evidence for effective collaborative processes for delivering and developing primary care would be sought in an increased sense of corporacy between members of the primary care community, between different professional groups, between management and clinicians. Given GPs' poor record of collaboration and their differences in status from other professionals, signs of GPs' preparedness to take ownership of collaborative ventures and operate in a more corporate fashion with the other primary care practitioners in their locality would constitute evidence of successful collaborative processes.

Primary care development/delivery – outcomes

Outcomes for collaborative delivery and development of primary care services could take various forms but would be manifest in the implementation of clinical governance and the development of specific services for patients.

4.8.3 Combining data from interviews and observation

Data from observation were collected as rough field notes and were used to provide a context in which to interpret interview data. This was done with a view to overcoming some of the limitations of relying solely on participants' reported views and experiences (generated data) or solely on observational (naturally occurring) data. Silverman (2001) criticises 'naïve' interview studies which hope that the limits of quantitative research are overcome by an open-

ended interview schedule and a desire to catch authentic experience. They fail to recognise the problematic analytic status of interview data which are never simply raw but are both situated and textual (Mishler, 1986).

I tried to be careful to avoid treating the actors' points of view as an explanations, and having additional, naturally occurring data from observations allowed me to contextualise generated interview data. At times having data from two sources altered my reading of a situation, and helped unpick inconsistencies in what people said. Over time, they provided a historical context for understanding the development of collaboration in an unfolding policy context.

4.8.4 Stages of data analysis

Data analysis, stage one: familiarisation

The first stage in the framework process of data analysis was familiarisation with the data, which was partly achieved through the process of transcribing interviews and notes from the non-participant observation. Next, a proportion of the interview transcripts, selected to represent a range of interviewee types (professions, employment) and date of interview, were re-read paying attention to the data's relationship to the *a priori* themes. During this familiarisation period, emergent themes were also noted. Examples of themes are:

- Practicing clinicians, elected by peers, on governing body (*a priori)*
- Introduction of locality-wide primary care body (*a priori)*
- Organisational turbulence (emergent)

The transcripts and field notes were then imported into NUDI*ST, which facilitated management, coding and retrieval of the large data set.

To illustrate the stages of the analytic process I employed in this research, I will use one *a priori* theme from the analytic framework (figure 6): the inclusion of practising clinicians on the PCG's governing board. This was a feature of its organisational form which was identified from the literature as one which would potentially help to foster collaboration.

Data analysis, stage two: coding

The second stage of the analytic process was to assign codes to the text units, the rough equivalent of short paragraphs, drawing on *a priori* and emergent themes from the theoretical framework. The coding process was inclusive, which is to say each section of text could be assigned as many different codes as appropriate, rather than choosing just one code for each section of text. The framework was evolving in the sense that, where a section of data did not fit it, but had something to contribute to the analysis, a new code was created.

In the coding stage, all sections of text in the interview transcripts where participants discussed their views on the inclusion of GPs and nurses on the PCG board were identified and assigned the code 'clinician board member' within NUDI*ST.

Data analysis, stage three: thematic charting

The next stage of the data analysis was to develop descriptive accounts of the range, nature and diversity of collaboration; looking for associations between different professional groups and their views and behaviours and comparing and contrasting their perceptions, accounts and experiences. Typologies – specific forms of classification that help to describe the key dimensions of collaboration and explain the way that phenomena may be differentiated or characterised – were developed.

In practice this meant arranging the coded text units in charts according to thematic reference. Each theme or subtheme, *a priori* or emergent, was assigned a column in the chart. Ritchie and Spencer's (1994) framework approach advocates assigning a row in the chart to accommodate the responses of each participant, but the number of participants in this study would have made such a table too unwieldy. Instead, reference was made to the framework which identified organisational position or professional group as contextual factors which would potentially act as driving forces for and against collaboration. Respondents were thus grouped accordingly into PCG/T board/PEC member; PCG/T manager; other GP; other community nurse; local authority officer; non-statutory body; and 'other.' Each group was represented in a row. A chart was drawn up for each theme, and entries made for each group of respondents. Rather than pasting the full piece of text from the interview transcript, a distilled summary of the respondent's views or

experiences was entered on the chart, along with a reference to the text unit so it could be readily traced to its source in the NUDI*ST database.

Data analysis, stage four: mapping and interpretation

The descriptive and typological work of 'charting' was followed by 'mapping and interpretation.' This involves finding patterns of association within the data and attempting to account for why those patterns occur. Linkages may be found between sets of phenomena and associations between experiences, behaviours, perspectives and certain characteristics of the study population. They enable the analyst to explain why the data take the forms that have been identified, and to account for why patterns, recurrent linkages, processes or apparent contradictions are found in the data. Ritchie and Spencer (1994: 184) identify this as the stage at which the "serious and systematic process of detection" begins, where the key objectives and features of qualitative analysis are met. Ritchie and Spencer warn that the analysis process is not simply about aggregating patterns, but weighing up the salience and dynamics of issues and searching for a structure rather than a multiplicity of evidence.

Staying with the effects of having clinicians on the governing bodies of PCGs and PCTs, as an example of the analytic process, the strategic and representative functions of board clinicians emerged as related but distinct dimensions of their roles. The changes over time in participants' views of the effectiveness and value of the inclusion of clinicians on the board as a means to foster collaboration were examined.

Participants' views of the value of clinician membership of the board varied, and the data analysis suggested/revealed that one of the main sources of this variation lay in the professional status and employment status of different professional groups. Nurses, a less powerful professional group than GPs, were initially enthusiastic about having a representative voice on a strategic body, and confident that their representatives would take their task seriously and carry out their roles well. However, their historical impotence in influencing strategy within the Community Health Trust (CHT) left some community nurses sceptical that they would be able to influence a body on which their interests would have to compete with those of GPs, a traditionally more powerful professional group. Within the nursing community were differences in views which related to the different employment status of district nurses and health visitors who were employed by the (CHT), and that of practice nurses who were

employed directly by GPs. Their employment status had implications for their capacity to attend meetings with their peers, and so to play a part in influencing PCG strategy. The most voluble dissent from the inclusion of practising clinicians on the PCG board came from senior CHT nurses. They had occupied strategic positions within the CHT, and argued that this experience was crucial to work effectively on the PCG board, yet they were not eligible for the positions on the PCT professional executive committee (PEC). Their positions, once the CHT had been dismantled, were very uncertain, and their opposition to the model must be understood in the light of the insecurity of their positions.

4.8.5 Validity

People frequently claim to be collaborating effectively, yet to find supporting evidence can be a struggle. It is also difficult to attribute changes specifically to the PCG or PCT; how can causation be established with any confidence? What constitutes *valid* evidence? Whose perspective matters (which is also related to pragmatic difficulties of access and recruitment)? Whose experiences and perspectives are relevant? What questions should be asked of them and how? Do the methods and sample illuminate the concepts? How can one be confident that what participants say has been correctly interpreted? How is rhetoric to be distinguished from reality? It is crucial to be alert to and to examine the various threats to the validity of the interpretation of the data and to consider how sensitive data analysis procedures may guard against them.

Interview respondents' answers could reflect a variety of possible scenarios: that they had never thought about the issues, that they were unaware of change even when there had been change, that they had not attributed changes to the PCG, that they had attributed changes to the PCG for which it wasn't in fact responsible, that changes had not filtered down or up to them. Amongst practitioners, some strategic issues were quite removed from their day-to-day work and had not been the subject of lengthy reflection. Similarly, more senior staff were sometimes unaware of operational issues.

Given the frequency with which participants expressed concern that they would not have helpful, useful or the 'right' answers, that they felt nervous, or that they feared the interview would be some sort of test they might fail, it is possible that sometimes people simply felt obliged to produce an answer: since the question had been asked it must have an answer. As Plamping et al

(2000 :1723) observed, "partnership has become a legal, almost moral, imperative in the health and social care world in recent years." Another potential threat to validity was that with such ubiquitous exhortation to work in partnership, it had became a kind of moral imperative. It is possible that participants were quick to profess their commitment to and activity in it, for fear of being exposed as not fulfilling their duties in this area.

Another issue to be raised is the one of 'interviewer effect'; how the interviewer may inadvertently act as an intervention. The interview questions frequently cause participants to reflect upon things they may not normally think about, and may well have a bearing on the way they act or practice. Again there is a need for sensitivity to the ways the researcher and research process shape the data collected. Many instances were recorded of, "Well, we don't really do that but perhaps we should."

Contradictory or incompatible accounts of an event or issue, within and between methods of data collection, were frequently recorded. How these should be interpreted or reconciled raises certain questions. Respondents' interpretations of the relevant research issues are what's important. I have accepted that their different vantage points will yield different types of understanding. This diversity of perspectives adds to our understanding of the various ways that reality has been experienced, and an underlying aim of this work is to apprehend and convey as full a picture as possible of the nature of that multifaceted reality. (Snape & Spencer, in Ritchie & Lewis, 2003). It could, for example, be concluded that individuals are (inevitably) only partially informed, that they are talking about a particular experience or incident that is particularly salient in their mind, but not necessarily a experience that reflects the generality of the practice, discipline or profession. To make this amount to more than idle speculation, it was necessary to look again to theory and methods to bolster the validity of the analysis.

Theoretical clues can be found in the literature on collaboration. For example, Glendinning and Rummery (1997) observe that the advantages and disadvantages of partnership working may not be evenly distributed between the parties. For example, when a social worker is attached to a primary care team, the practice gains a person and perhaps quicker referrals, but the social worker loses support and supervision. Crawford (1998) identified "fundamental conflicts over ideology, purpose and interests, and differential power relations between the partners" as key to the major implementation

difficulties experienced in partnerships and these might influence the narrative of an interview.

In an ideal world, a methodological safeguard would be to interview the most peripheral players first, working inwards towards the most central, using iterative data gathering techniques to build a picture and refine the research questions along the way, developing themes, identifying issues and raising them with subsequent interviewees. This technique would allow the researcher to refine theories and subsequently to pursue lines of enquiry in further depth (Pope et al, 2000). In some sense it would be almost impossible *not* to think about what is heard as the data collection proceeds, and for that to feed into ensuing data gathering. In practice the extent to which this was achieved was limited by the process of securing interviews, which was so difficult to regulate that concurrent formal data analysis was not always feasible. The more salient issues that came up were carried over; some of the more subtle ones may have escaped.

Follow-up interviews provided an opportunity to seek some degree of respondent validation, enabling a comparison of the researcher's account with the respondent's account. However, the difficulty of relying on this as a guarantee of validity is that any vested interests that shaped the original data gathering would apply equally to the process of respondent validation.

Melia (1997) raises the question: "Are the data to be regarded as straight accounts of the interviewee's experiences or stories about that experience told as an exercise in self-presentation by the interviewee?" To some degree "triangulation," the process of comparing results from either two or more different methods of data collection (e.g. interviews and observation) or two or more data sources provides a safeguard against this. Patterns of convergence are sought to develop or corroborate an overall interpretation. Since multiple methods were employed in the present research, this has been attempted. However, triangulation is criticised as a test of validity because it assumes weaknesses in one method will be compensated by strengths in another, and that it is always possible to adjudicate between different accounts. Rather it was viewed as a way of ensuring comprehensiveness and encouraging reflexivity than as a pure test of validity.

A method of bolstering claims to validity that has already been touched on is reflexivity. Other aspects of reflexivity are an appraisal of the effects of personal characteristics, such as age, sex, social class, professional status and

the "distance" between the researcher and the researched on the data collected.

Fair dealing means ensuring that the research design explicitly incorporates a wide range of different perspectives so the viewpoint of one group is never presented as if it represents the sole truth about any situation. This too was problematic in the present research, where there is an almost infinite number of perspectives; which should be chosen? In researching the local treatment of drug users in primary care, for example, there was certainly some self-selecting bias amongst GPs. It was possible to interview a broad range of GPs from practices which were broadly sympathetic to treating drug users, but those from practices which preferred not to take drug users on their lists were generally unwilling to engage with the research process. Again, these matters of recruitment and access are linked with issues of power.

Finally, it is important to offer a clear exposition of methods of data collection and analysis. Methods used in data collection unavoidably influence the objects of inquiry (they influence what is collected, what is offered, what happens, what people do), so a clear account of the process of data collection and analysis is important. A written account should include sufficient data to allow the reader to judge whether the interpretation offered is adequately supported by the data. This chapter has aimed to provide such an account.

4.8.6 Explanatory accounts

Qualitative explanations attempt to say why patterns and outcomes in the data have occurred. These explanations may use a causal logic in a loose, non-universal, non-deterministic sense, but the logic is not based on linear variable analysis. They rarely cite a single cause or reason, but set out to clarify the nature and interrelationship of different contributory factors or influences - such as personal intentions, patterns of understanding, norms and situational influences. Sometimes explanations will be offered with some certainty because of the strength of the evidential base. Other times they will be suggested as hypotheses which need to be tested in further research.

Chapter five: Health improvement

5.1 Overview

This chapter is the first of three findings chapters which examine the PCG's and PCT's collaborative capacity and practice, the third element identified in the realist theoretical framework.

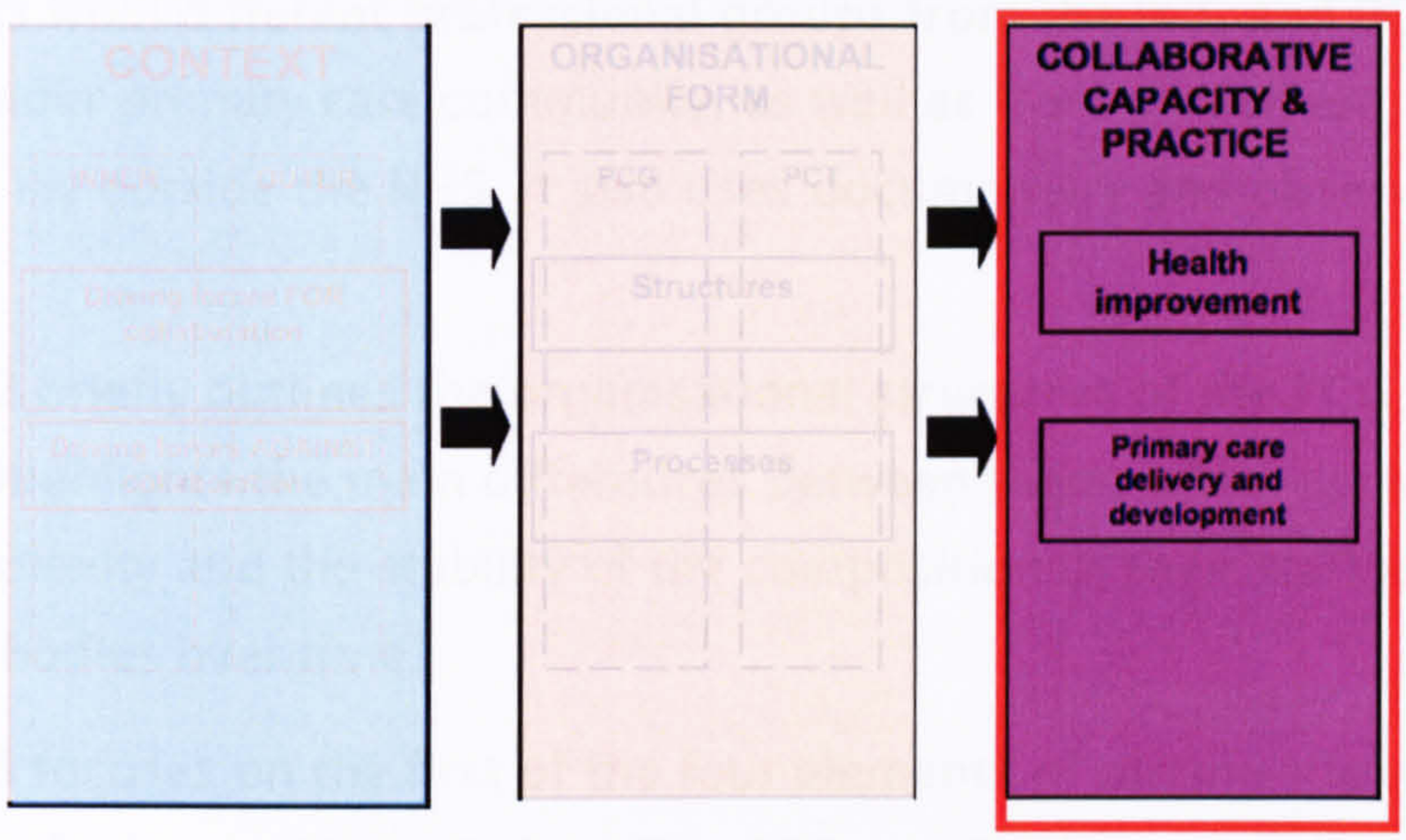

Figure 8: Realist theoretical framework – collaborative capacity

As chapter three demonstrated, the New Labour government gave PCGs and PCTs a remit to improve the health of their population. The early guidance was to adopt an approach to this which considered a wider range of determinants of health and thus required a more collaborative model than primary care had traditionally taken. This chapter addresses research question 3 (see p80) which draws on the analytical framework of figure 6 to identify four features of the organisations' forms which were likely to facilitate collaboration.

RQ3 How far did the following features of PCGs' and PCTs' organisational forms allow them to bring about a collaborative approach to improving the health of their population?

- Their explicit health improvement remit
- Their locality-wide base
- the election of practising clinicians to their governing bodies

- the inclusion of a local authority social services department (SSD) representative on their governing bodies.

This chapter asks whether these four features equipped the two organisations with the **collaborative capacity** to adopt this more public health-based approach to improving the health of their population. It explores how each element of the context identified in the analytic framework helped or hindered the PCG and PCT to build collaborative relationships.

It draws on interview data to illuminate the experiences and perspectives of participants from different professional groups from the PCG and PCT and from the wider primary care community, as well as from participants whose main work lay outside the NHS. It also uses documentary and observational evidence.

Section 5.2 briefly outlines the organisational structures of the PCG and PCT in Oxford. It highlights the main differences between them, which lay in their scale, complexity and the stability of the composition of their staff and governing bodies over time.

Section 5.3 focuses on the first of the four elements of organisational form, examining whether and how Oxford City PCG and PCT's explicit health improvement remit facilitated their adoption of a more collaborative, public health-oriented approach which focussed attention on broad determinants of health. To do this, it eplores how the PCG and PCT interpreted their health improvement remits: the process by which health improvement priorities were identified by each, how health improvement strategies were devised, and how progress was made and assessed against them.

It argues that the PCG's explicit health improvement remit, which was new to primary care, was effective in stimulating a more upstream, public health-focused approach to to addressing determinants of health than primary care had previously adopted, and in initiating collaborative ventures with local authority and non-statutory bodies to pursue such an approach.

Two aspects of the outer context supported this upstream approach to health improvement by the PCG. First, in line with its third way rhetoric, central government took a facilitative, hands-off role and, second, it emphasised the importance of tackling complex social problems. These two elements of the context allowed the PCG to identify locally relevant, non-medical health improvement priorities. They also made for a policy environment in which the

creativity and personal commitment of the PCG's HImP group members and boundary-spanners from other organisations could thrive in pursuit of them.

It argues that the PCT's explicit health improvement remit was less effective as a means of underpinning an upstream approach to health improvement. Although the PCT was also charged with improving the health of its local population, it operated in a policy context in which the government's rhetorical commitment to the third way was undermined by an emphasis on medically-oriented, centrally-defined targets, which was not conducive to a collaborative, public health-oriented approach. Organisational change and major staff turnover from PCG to PCT further impeded the health improvement remit of the PCT by damaging the collaborative relationships that had been established between the PCG and local authority and non-statutory bodies, and disrupting the grassroots, public health-oriented work initiated under the aegis of the PCG.

Section 5.4 considers how having in place locality-wide structures facilitated primary care's adoption of a more collaborative, public health-oriented approach to health improvement. It argues that a consequence of having a locality-wide primary care structure was the development of subgroups to carry out such work across that geographical area. It focuses on the health improvement subgroups established by the PCG and PCT and asks whether their composition and terms of reference enabled primary care to collaborate with other statutory and non-statutory bodies for health improvement. It asks which individual and organisational factors facilitated and inhibited such collaboration.

It argues that the city-wide geographical scale of the PCG and PCT was a necessary but not sufficient condition to support a more strategic approach to tackling health inequalities than had been available to the fragmented pre-PCG primary care community. The introduction of the PCG - coterminous with the City Council and with its explicit health improvement remit - supported a city-wide subgroup established to implement the health improvement frameworks described in 5.3. This allowed collaboration with parts of the local authority and non-statutory organisations for health improvement on a city-wide scale. The group's terms of reference and composition facilitated an upstream approach to health improvement.

The PCT covered the same geographical area and had a subgroup with a responsibility to lead health improvement activity in the locality. This section

It argues that collaboration between some departments of the local authority and the PCG was strong, but this did not result from the inclusion of the SSD representative on the board. The failure of this as a collaborative mechanism was due in part to a two-tier and fragmented local authority and the prolonged absence from work of the SSD representative. Instead, collaboration evolved through, and was maintained by, the efforts of a small number of boundary-spanners from the PCG and the city council. In parts of the city council where no boundary-spanner emerged (for example, the housing department), collaboration was much less evident.

Representation of SSD survived the transition from PCG to PCT but, since this was not the mechanism for health improvement-related collaboration between the local authority and the PCG, it did not sustain collaboration with the PCT.

Finally, **section 5.7** summarises the findings about the PCG's and PCT's collaborative activity to improve the health of its population. It assesses the differences between the two organisations' approaches and relates them to contextual factors identified in the framework in section 3.7.

Overall, chapter five argues that two of the features of the PCG's organisational form, its health improvement remit and its locality-wide base, effectively facilitated an upstream approach to health improvement. Factors of the outer context which acted most strongly as driving forces for collaboration were the hands-off, facilitative role of central government, consistent with its third way rhetoric of collaboration, and the prominence afforded to tackling complex social problems.

The transition to PCT and differences in the context in which it operated, disrupted collaborations forged by the PCG. In particular, the increasingly target-driven, centrally controlled health improvement agenda changed the focus of public health efforts to a more strongly medically-oriented one. It was therefore less effective than the PCG as a collaborative mechanism for upstream health improvement.

The other two factors, local authority representation and the election of practising clinicians by their peers to the governing bodies of the PCG and PCT did not enable collaboration to come about. These were inhibited by organisational and cultural barriers, the traditionally medically-oriented approach to health of GPs, and the scant history of collaboration in general practice.

5.2 Organisational structures of Oxford City PCG and PCT

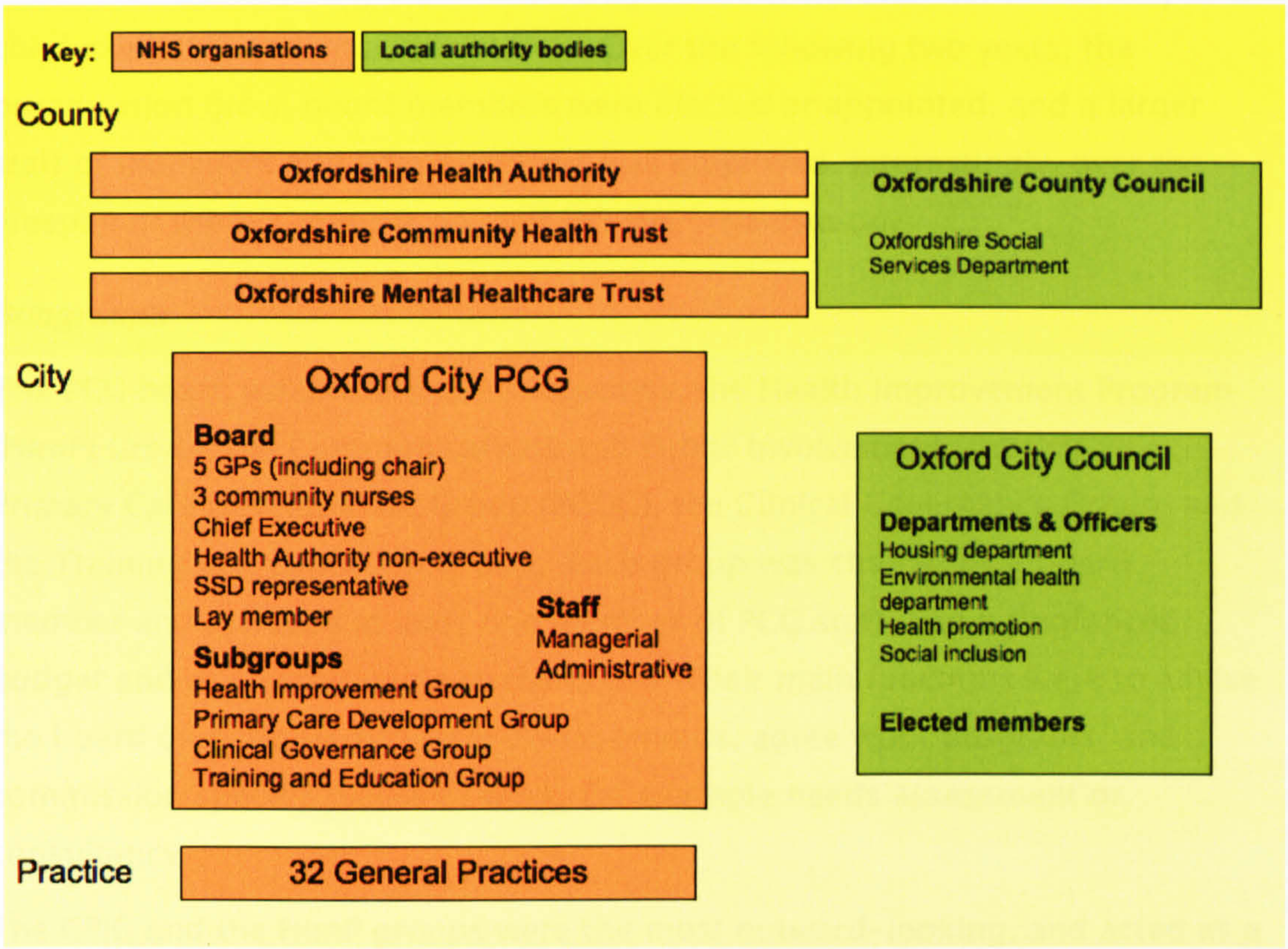

Figure 9: Structure of Oxford City PCG and related NHS and local authority bodies

This section begins with a brief overview of the structure of Oxford City PCG and PCT, their subgroups and staff.

5.2.1 PCG structure

The board which governed Oxford City PCG had responsibility for the main decisions on the organisation's policy, strategic and financial direction. It was dominated by clinicians who had been elected by their peers, comprising altogether

- 5 GPs (including chair)
- 3 nurses
- Chief executive
- Health Authority non-executive
- Social services department representative
- Lay member

Staff

When the PCG originally went "live" in April 1999, the staff consisted only of a chief executive and an administrator. Over the following two years, the organisation grew, board members were elected or appointed, and a larger staff of managers and administrators was employed. Interestingly, over the lifespan of the PCG almost no staff left the organisation.

Subgroups

The PCG board established five subgroups: the Health Improvement Program (HImP) Group, the Communications and Public Involvement Group (CPIG), Primary Care Development Group (PCDG), the Clinical Governance Group, and the Training and Education Group. Each group was chaired by a board member and included at least one member of PCG staff, had a ringfenced budget and was accountable to the board. Their main functions were to advise the board on national and local developments, agree work programs, and commission specific pieces of work, for example needs assessment or consultancy.

The CPIG and the HImP groups were the most outward-looking, and acted as a conduit to the wider health and social care infrastructure in Oxford. Their flexible composition and activity meant in many ways they were better placed than the board to engage partner organisations and facilitate collaboration at a local level.

5.2.2 PCT structure

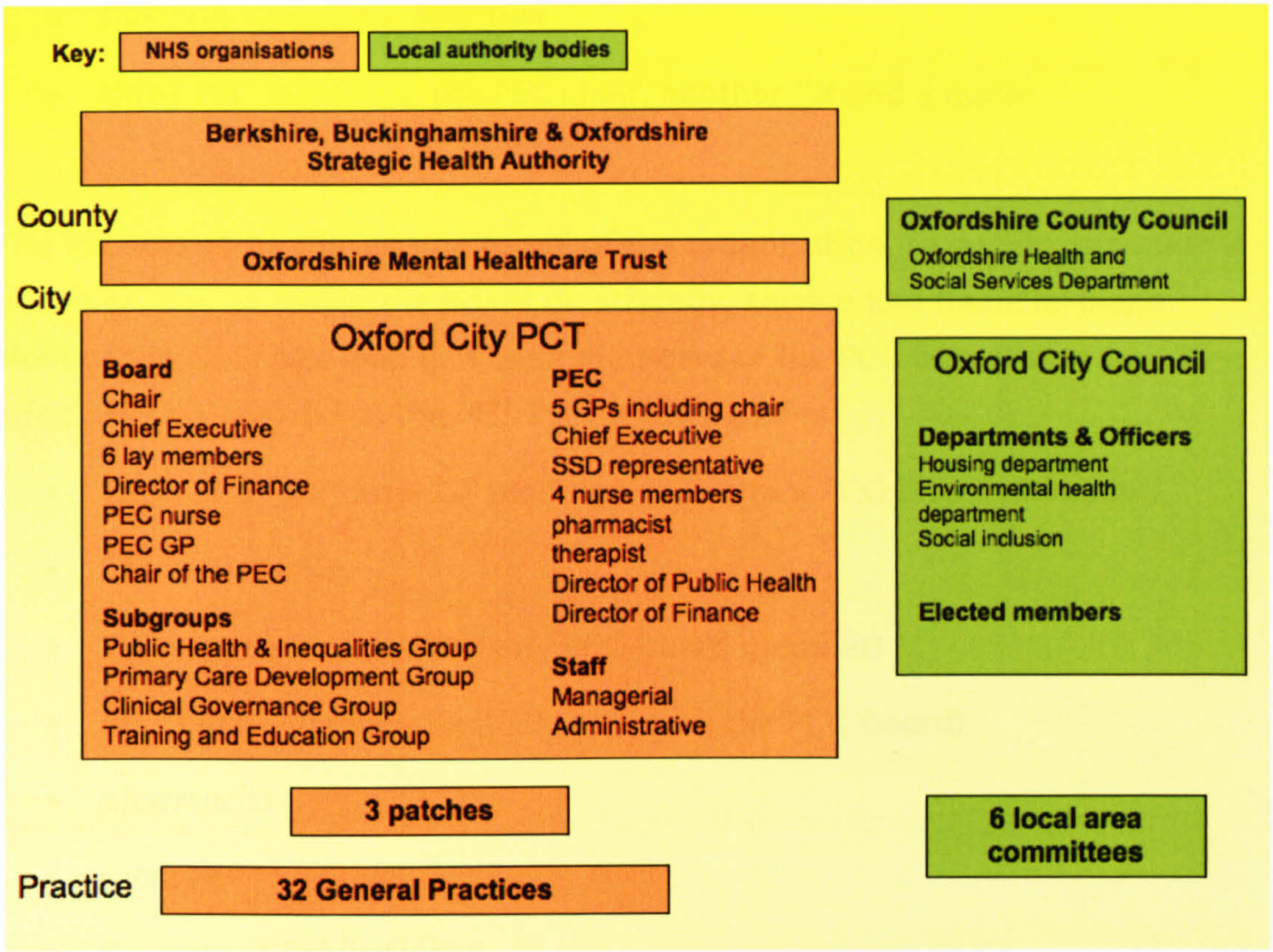

Figure 10: Structure of Oxford City PCT and related NHS and local authority bodies

To meet the considerable increase in its responsibilities, the DH required that PCTs adopted a much more complex and bureaucratic structure than the PCG [see figure 10]. At the highest level, this involved the separation of the board from the professional executive committee (PEC). There was some overlap between the membership of these bodies to allow co-ordination and the smooth running of the PCT as a whole.

The role of the board was to set the overall strategy of the PCT, to take responsibility for spending public money, to monitor the performance of the PCT including finance and service delivery, and to ensure PCT actions met local needs and involved communities. Membership of the board was almost entirely lay: it comprised

- Chair
- Chief executive
- Director of Public Health
- Director of Finance and Performance

- Director of Quality and Professional Development
- five non-executive directors
- three PEC members: the PEC chair, another GP and a nurse

The PEC was to be the 'engine room' of the organisation, to decide operational priorities, and to advise the board on strategy, service and financial plans.

Most of the clinicians who had been members of the PCG board were effectively transferred to the PCT PEC. It consisted of

- Chair and four other GP members (all former PCG board members)
- Chief executive
- SSD representative (formerly PCG board member)
- four nurse members (initially two from the PCG board)
- pharmacist
- therapist
- Director of Public Health
- Director of Finance and Performance.

The GPs and SSD representatives provided considerable continuity between the PCG board and PCT PEC. The main differences between the two bodies were the addition of another nurse, a therapist and a pharmacist. GPs did not hold the majority of places on the PEC, and it included no lay member.

PCT Staff

The staff turnover in the first year of the PCT was enormous. Few of the administrative or managerial staff who had worked in the PCG were still employed by the PCT by the end of 2001.

A major administrative change which accompanied the establishment of PCTs in Oxfordshire was the dissolution of the Community Health Trust (CHT). As a result, community nurses and most of the other staff formerly employed by the CHT became employees of the PCTs.

Subgroups

The subgroups transferred intact, for the most part, from PCG to PCT. The main differences between the PCG and PCT subgroups were in the transition from the PCG's HImP group to the PCT's public health and inequalities (PH&I) group. These differences are examined in the section 5.4.

5.3 Health improvement remit

Under the aegis of the PCG and PCT, primary care had, for the first time, responsibility to improve the health of the local population (a responsibility which was distinguished from the delivery of primary care or commissioning secondary care) through addressing wider determinants of health than mainstream NHS service provision traditionally had. As chapter two argued, the PCG's and PCT's responsibility for health improvement required a fundamental change in outlook for primary care: from a predominantly downstream approach to a more upstream approach. Primary care professionals, particularly GPs, had traditionally adopted a predominantly medical, individual perspective on health care and had little history of collaboration. The drive towards a preventive, public health-oriented approach to health improvement seemed, therefore, ambitious for an organisation which placed those health professionals *"in the driving seat"* (Secretary of State for Health, 1997: para 5.1).

This section asks whether and how Oxford City PCG and PCT adopted a more collaborative, public health-oriented approach which focussed attention on broad determinants of health. It examines the process by which health improvement priorities were identified and how progress was assessed against them.

5.3.1 PCG upstream health improvement model

The main framework for Oxford City PCG's health improvement work was its Health Improvement Programme (HImP). As chapter three described, the HImP was a local plan of action which was expected to bring together people from various parts of the NHS (primary and secondary care) with local authorities and other agencies and organisations to improve health and reduce

inequalities in health by tackling broad causes of ill health. Oxfordshire's HImP provided the overarching framework for health improvement for the whole county's population. Each of the six PCGs within Oxfordshire Health Authority's boundaries identified their own local priorities, and developed plans to meet them.

Oxford City PCG's local HImP priorities were identified through 'bottom-up' consultation process, i.e. priorities were identified by those closest to the community being served, rather than imposed by senior policy makers. The consultation process was rapid but extensive and inclusive, involving community groups, independent and voluntary sector organisations, as well as NHS organisations and local authority departments. This inclusiveness was reflected in the orientation of the five priorities which emerged from the consultation, which was non-medical compared to those of other PCGs in the county, and to the traditionally medical and individual focus of mainstream primary care which was designed to react to illness than proactively to improve health. The priorities agreed by Oxford City PCG for its 1999/2000 HImP were:

- mental health
- substance misuse
- reducing inequalities in health
- housing and homelessness
- promoting independent living in older people and people with disabilities.

The significance of these HImP priorities was that, for the first time in primary care, the promotion of public health and prevention of ill health by addressing broad, non-medical determinants of health, were formally endorsed and legitimised. This was a welcome development for people who supported this approach, but had previously found it difficult to do so within the NHS.

> *What was new and interesting and exciting about HImP was that it was the first time you could overtly be working on things that were not to do with treatment. It was broader, you were looking at prevention, and it was formalised in a structure, looking at inequalities.* [health development manager 1]

They aimed to tackle complex social problems which the PCG could not address alone: collaboration with a range of other organisations was crucial to

its success. To pursue a non-medical, public health model, PCGs had not only to engage with their primary care community, but also with a range of non-statutory organisations, including the voluntary sector. This section explores how the PCG's commitment to a collaborative approach to health manifest itself in collaboration with other such organisations to address broader determinants of health.

The PCG's HImP group broke from traditional methods typically employed by NHS bodies in consultation and needs assessment when it initiated collaboration with non-statutory bodies such as the Unemployed Workers and Claimants' Union, which had previously had little or no contact with a statutory health service body. This brought significant change in both sides' perceptions of one another. The Union was initially commissioned to undertake the community involvement element of the consultation on becoming a PCT, using participatory appraisal methods to access 'hard-to-reach' groups including older people, drug users, young people, people with mental health problems, and refugees. This bottom-up, qualitative approach which was designed to meet the consultation requirements through a process which would empower and meaningfully involve members of the community.

Assessment of progress against HImP (Stakeholder workshop)

The HImP Action Plan originally acted as a guide for the implementation of the health improvement priorities. Milestones and outcome targets were identified, but their outcome measures were generally non-quantifiable proxies for long-term goals, not quantifiable short-term targets. The assessment of progress against these priorities was taken seriously by the PCG.

In addition, in September 2000 the PCG held a HImP Stakeholder Workshop to which people whose work was connected to the HImP priorities were invited to share experiences, information and achievements in health improvement work to date and to discuss and shape its future. I attended this workshop, along with a wide range of people including, from the statutory sector: PCG staff, PHCT members, the Community Health Trust, social services, City Council officers and councillors, and the universities. Representatives of the independent sector included Age Concern, MIND and other mental health charities, MENCAP, The Gap (a day centre for young homeless people), nightshelter, housing associations, Dialability, drugs agencies and rehabilitation centres.

Feedback from the event indicated that the inclusion of health inequalities on the policy agenda was very strongly welcomed. An increase in collaboration with the City Council, and particularly the Environmental Health department, on a broad range of issues was highlighted as a success as well as an area where there was potential for more work. There was thought to be scope for greater involvement of the voluntary sector in tackling health inequalities. Action points from the workshop included keeping the profile of the HImP raised, recognising other partners' work, highlighting the relevance to all organisations and within organisations and the public (minutes of HImP group meeting, 2nd November 2000).

The East Oxford Single Regeneration Budget and the Healthy Living Initiative bid were praised for recognising wider health needs and fostering joint work, including public involvement (minutes of HImP Group meeting, 2nd November 2000).

The collaboration-related language, ubiquitous in government rhetoric, was increasingly being used by local managers in both the health and social care sectors. It was argued by some that this made collaboration more likely to come about than it had been previously. It was seen as a worthwhile goal, which had not always been the case.

> *I think clear partnership working, we haven't got it at the moment. We've got lots of good intentions, and that's much better than it was before where it was a real siege mentality and no-one spoke to each other. I think if we were to have this conversation 10 years ago, everyone stuck to their own thing, and I think that's wrong when you work in the public sector because you're all paid by the same people. (City Council Officer: health promotion)*

Collaborative relationships with non-statutory bodies

The Union's work continued beyond the period of the PCT consultation as they trained facilitators from within the target groups and developed the beginnings of a network of community facilitators which would then be in place for future consultation and needs assessment.

This and other opportunities taken by members of the HImP group to engage in the work of non-statutory and community groups on their terms signalled a commitment to work collaboratively with a broader range of organisations and step out of the traditional, medically-focussed NHS role. Because this approach

was new to primary care in many ways, its legitimacy was challenged at times by board members. However, much of their initial resistance was overcome by the health development managers who persuaded sceptics of its value.

5.3.2 PCT implementation of NHS Plan & NSFs

The PCT inherited the PCG's responsibility for improving health, but the way the two organisations carried out this work differed from one another. Targets were set in the *NHS Plan* and National Service Frameworks (NSFs), and all PCTs were performance managed against them, so the focus of the PCT's health improvement work became the implementation and performance management of the *NHS Plan* and NSFs. These differed from the HImP priorities in two important ways: they had been identified as priorities by central government rather than by local stakeholders, and overall, the *NHS Plan* had a stronger medical orientation.

The *NHS Plan* priorities were accepted by most PCT staff as legitimate and uncontroversial areas of work to tackle ill health. As it became clear that the top-down forces on health improvement work were irresistible, efforts were made to work with them and incorporate them into locally relevant work. Some cautiously welcomed the transparency and accountability implied by the performance management. The public health and inequalities (PH&I) group worked to align upstream and downstream approaches to health improvement. They tried to fit locally relevant work around the centrally imposed targets and to manage the tensions between them and local need. Although it demanded a change in their working practices, they worked to accommodate the targets, and conceded that it was beneficial as a motivating force in certain respects. They became adept at presenting locally relevant work in ways that fitted with targets, without allowing their work to be dictated completely by these targets.

> *Oh you can interpret it so it's synchronised totally. And local need fully blends in with the national agenda... It was described as a tension and I don't see it as a tension at all. They're complimentary. If you look at the epidemiological data, the people who are not coming forward – the low take-up rates and the lack of access are amongst the people who are most deprived and therefore you need to reduce that gap and promote access.* (health development manager 2)

You have to do the must-do's, because, you know, the NHS Plan says so, and we're committed to doing that locally. Even if you're doing what you're doing, you have to try to phrase it, if you can, in terms of one of the NHS Plan target areas, or one of the other guidances coming out. And probably most of the work that we do, you can find a slot for it somewhere. (health development manager 1)

However, the absence of national targets relating to reducing health inequalities meant that it was easily sidelined, and that developing collaboration around locally determined areas for health improvement was afforded lower priority. Members of the PH&I group who had been HImP group members were concerned that a preoccupation with short term, quantifiable targets would detract attention from longer term, more diffuse aspects of health inequalities.

It's probably not a bad thing that you've got to be able to monitor it and have targets, but the irony is, in terms of health inequality, there aren't any national targets yet, because it's so hard to find those. (health development manager 1)

There's always a tension between what has to be done, the service delivery side of it, and health promotion will always lose out. If you look at the targets set in the National Plan, the latest document that we've got to follow, they're quite medically orientated again. (City Council Officer: health promotion)

All the new guidance coming out is tending to swamp the original idea of narrowing the health gap, and the broader causes of ill-health, and so on, with targets, with monitoring, and with the NHS Plan. It means that health improvement is likely to be the way that the NHS Plan is performance managed. (health development manager 2)

Increasing central control and prioritising nationally identified areas bore an opportunity cost. Other issues which were held locally to be very important risked being neglected as human and financial resources were dedicated to meeting centrally prescribed targets.

The work to tackle substance misuse exemplified this. This was an area of collaborative work whose profile had been raised by the PCG and which had made progress and garnered significant support locally, yet which risked being

sidelined as the PCT pursued the areas on which its performance would be measured by the Strategic Health Authority or Department of Health for star ratings. This is further explored in chapter seven.

Implementation of the older people's National Service Framework (NSF) illustrated the perverse effects of target-setting on areas of care for which targets were not set. Falls prevention was one of the areas highlighted by the NSF, but PCT management chose not to address it until pressure was exerted to meet a target. One nurse PEC member identified this as an example of the differences between the extent to which practitioners and managers were motivated by targets. She contrasted her approach as a clinician with what she perceived to be the target-obsessed culture of NHS management which, without targets, would neglect important health needs. She observed that the PCT's preoccupation with targets had increased relative to the PCG and attributed this partly to a dilution of the influence of practitioners on the PCTs' governing bodies and an increase in the proportion of managers.

> *But I have been very disillusioned talking with a senior lead for the NSF for older people about falls prevention and falls reduction, and this person said in spring 2002, 'I'm not going to do anything on this, standard 6, which is about falls reduction, until the autumn because the targets don't come through 'til 2003 and 2004.' I heard that and I thought, 'people fall over every day, and the impact of falls on an older person are often devastating'. The statistic about the number of people who are dead within 6 months of a NOFF [neck of femur fracture] - about 46% of them are dead. Six month morbidity with a fractured neck of femur is huge, and the impact for the individual is huge.* (PCG board/PCT PEC nurse)

This illustrates the tensions felt between clinicians and managers.

Assessment of progress against targets

The increasing emphasis on performance management of the PCT brought about what was referred to as a 'target culture.' This was particularly salient in its approach to work relating to health improvement. While the HImP group proposed to *"ensure that project work to achieve local HImP priorities [was] evaluated"*, the PH&I group was more driven to achieve explicit outcomes and meet quantifiable targets:

> *to agree milestones, targets and where possible, measurable outcomes to be used to assess progress against the work plan. (Oxford City PCG HImP Group, 2001)*

The key performance indicators for health improvement against which the PCT was to be judged were predominantly medical[4].

As the change in focus became apparent around the time of the transition to PCT, the implications for the health improvement work were noted by the former members of the HImP group who anticipated great change.

> *The targets. I think that if we do focus too tightly on the tiny little bean counting then you're not looking at the bigger agenda than what's going on in front of you. It's frustrating. If the government's looking at, I don't know, how many bits of heart disease are treated with this drug, and takes its eye off the fact that we're creating cycles of poverty that are intergenerational, then I think they're missing a real issue.* (City Council Officer: social inclusion)

By the time the PCT's first annual report was published in July 2002, 24 targets had been identified on which the PCT was performance managed, and the PCT's performance against them was reported to each board meeting. The PCT would be judged on 21 of these by the DH and Thames Valley Strategic Health Authority. The other three, related to the PCT's financial balance, access to primary healthcare professionals, and access to emergency services, would be used to calculate the PCT's 'star rating'.

> *I think we've moved into a very strong medical model of public health. I regret that but I'm going to have to work with it. I think those days have gone. As you say the links are made at strategic level but my feel is at the moment less at operational level than they used to be.* (PCG board/PCT PEC nurse)

> *I think there's still a real problem with health being around medicine and emergency care and hospitals and not being about housing and streets and crime and poverty... Within the PCT I think health inequalities have gone right down the agenda and that what we*

---

[4] See section 3.4.2 for list of performance indicators

mean by them is not the same thing. Certainly when I met with [one of the public health team], he wasn't really interested in talking about projects unless we could prove a medical impact, and of course that's quite difficult to do with anything from increased leisure provision to housing. It takes ages for the health impacts to show. (City Council Officer: social inclusion)

There was recognition that the new performance management had some benefits, but it also felt more coercive and less facilitative, and was sometimes accompanied by heavy-handed punitive forces, perceived to be biased in favour of secondary care and not always compatible with meeting locally identified needs. The threat to "name and shame" people and organisations which failed to meet targets and achieve standards within a particular timeframe was felt to be unconducive to generating collaborative relationships. The requirement for individual organisations to meet separate and sometimes conflicting targets was similarly felt to distract attention from longer term, wider determinants of health such as poverty which required long-term co-ordinated strategic efforts from a range of public sector organisations.

I think that all the time you have such heavy pronouncements, all the time you have the threat of people being named and shamed and the threat of jobs going and resources being transferred and the rest of the nonsense, all the time you have that Stalinist approach to healthcare, you will get in the way of generating organic partnerships. That isn't to say that setting standards is a bad thing, but it's the 80:20 rule - how do we interpret this standard in our circumstances? That's the 80% we can deliver you; we've got to work on the other 20%. But when you've got a focus in that league table mentality on secondary care, and specific aspects of secondary care, it will get in the way of developing more strategically sensible, locally relevant stuff. And you just keep banging away and pouring money down the OR's [Oxford Radcliffe, acute trust] throat which is what we want to stop doing. (PCG/PCT lay member)

Summary: This section asked whether and how Oxford City PCG and PCT adopted a more collaborative, public health-oriented approach which focussed attention on broad determinants of health. It examines the process by which health improvement priorities were identified and how progress was assessed

against them. It argued that the PCG's health improvement remit legitimised upstream approach to this area of the PCG's work, and this was facilitated by the support of the outer context which emphasised collaboration and complex social problems, and the personal commitment of boundary-spanners in the inner context. However, this was undermined in the PCT by a context which was more centrally controlled and by organisational turbulence which was disruptive of nascent collaborative relationships.

5.4 Locality-wide primary care organisation

As chapter two set out, many social and environmental determinants of health are tackled more effectively at a wider geographical level than at an individual GP or practice level. Many are also influenced more by local authority and non-statutory bodies than by NHS bodies. The PCG and PCT were locality-based primary care organisations, an arrangement which contrasted significantly with the fragmentation of primary care and independence/autonomy of GPs prior to their introduction. In Oxford they were coterminous with the City Council, many of whose functions derived from public health origins. This implied an opportunity for primary care to develop a more strategic approach to collaborating with the City Council and other organisations to pursue health improvement objectives for the population of Oxford than had been possible when primary care was an assortment of unconnected practices. This section considers how the existence of these overarching locality-based structures facilitated primary care's adoption of a more collaborative, public health-oriented approach to health. It focuses on the subgroups each established to implement the health improvement frameworks described in 5.3, and asks whether their composition and terms of reference enabled collaborative working for health improvement. It asks which individual and organisational factors facilitated and inhibited collaboration.

5.4.1 PCG's HImP group

The main responsibility to develop the PCG's health improvement framework was given to the Health Improvement Programme (HImP) group. It was multi-disciplinary and multi-sectoral, and was set up explicitly to take forward

Oxford City's contribution to Oxfordshire Health Authority's countywide HImP. This section examines how the HImP group's terms of reference, its composition, activity and character and its relationship to the rest of the PCG and the primary care community suited it to facilitating collaboration for health improvement.

HImP group terms of reference

The HImP group's Terms of Reference (November 1999) placed a strong emphasis on working with other parts of the PCG, as well as with the wider primary care community and beyond. Among its purposes were:

- *In partnership, to formulate plans for local action on agreed local HImP priorities;*
- *To encourage primary care teams to become involved and have ownership for the PCG's HImP priorities related work;*
- *To ensure that links are made to other aspects of Oxford City PCG's work (including primary care development, clinical governance, and commissioning);*
- *To discuss national and local developments in health improvement, public health and health promotion and advise the PCG board.*
- *To engage in an open dialogue with partner agencies and primary care teams on health improvement, public health and health promotion issues.*

The Primary Care Investment Plan (PCIP) reinforced the theme of collaboration and involvement of a wide range of people, stating that the HImP group's work would be:

> ... taken forward via partnership working through a range of working groups, primary care staff involvement, community involvement, information gathering to inform future work, training and education strategies, and service developments. (PCIP 1999–2002, September 1999).

HImP group composition

The original membership of the HImP group signalled high-level commitment to its work; it included six PCG board members, including the chief executive, two GPs (one of whom chaired the group), a health visitor, the SSD

representative, and the board lay member. Membership from the City Council, Community Health Trust Health Promotion, the Health Authority and the Community Health Council (CHC) also reflected that the nascent organisation was reaching out beyond the immediate primary care community.

Two key members of the HImP group were the health development managers, members of the PCG staff. Their posts were jointly funded by the PCG and the City Council in recognition of the overlap in their responsibilities, in itself a manifestation of their combined commitment to collaboration on health improvement and the support for it at a senior level of both organisations. They were employed by the PCG, and based in their premises. They both had backgrounds in community development and the voluntary sector, and their role was to manage the implementation of the HImP with a focus on development, prevention and long term public health initiatives. They played a key role in developing the health improvement agenda and projects with a range of organisations, agencies, community groups and voluntary organisations, including the City Council. One of them chaired the HImP Group.

The HImP recognised that the distinctly non-medical nature of the Oxford City PCG's HImP priorities would require broader input still. The need to include representatives of the voluntary and community sectors, black and minority ethnic groups, and specialist areas of expertise that may be required, was acknowledged early on. To ensure group members had sufficient authority and influence within their organisations to undertake meaningful collaboration, it was stipulated that

> *Members of the group should be able to speak for their own organisations and to take back issues for action to their own organisations and networks.* (HImP Group terms of reference, November 1999).

Over the first six months of the PCG's lifetime, the membership of the group changed considerably. Both GPs and the chief executive withdrew, so its membership became less senior and less 'medical'. The health visitor board member became chair when the GPs withdrew. From this point on, a core HImP group membership, from the local authority and a range of community-based organisations, remained committed and active in the group's work.

HImP group activity and character

The HImP group brought together Oxford-based organisations to work to improve health. Its monthly meetings were attended by City Council officers, PCT staff (including, initially, the PCG chief executive), other organisations and, at first, two GPs. These meetings provided a forum where individuals could enhance their understanding of each other's professional and organisational cultures and explore opportunities for collaboration. Through them the Health Promotion Department of the city council had a great deal of contact with the PCG chief executive and chair, and they built strong, trusting relationships.

> *I think it's certainly opened a lot of eyes in the Local Authority about the role and status of GPs. I think they were a bit of a mystery group before and certainly, going to lots of meetings with them, I understand that they come with a particular view: small businessman basically, and a cautious group. So it's very valuable to understand those issues from their point of view.* (City Council Officer: health promotion)

The PCG was also well linked into the City Council's work to promote social inclusion. One member of the HImP group was the City Council's social inclusion officer, who worked with the PCG and the practices within it to introduce a pilot scheme called "Benefits in Practice" which installed benefits advisors in certain GP practices with high levels of deprivation to make benefits advice more accessible to patients. It was also closely involved with the East Oxford Healthy Living Initiative (HLI), a non-statutory sector initiative, funded by the National Lottery New Opportunities Fund, with a focus on community-level action to promote health and reduce health inequalities. Its five main areas of work were healthy eating; improving access to health services by enabling health professionals to bring services to community groups; improving access to complementary therapies for low-income groups; and the provision of childcare and supporting volunteers.

The HImP group had the most eclectic membership of all the PCG's subgroups, and an enthusiastic and vibrant atmosphere. Observation of its meetings allowed me to witness the palpable commitment, drive and enthusiasm of the team of PCG staff who led the HImP work. Almost from the inception of the PCG, there was an awareness that it was a transitory body which was working towards PCT status. The transition occurred more quickly than had been anticipated, and staff were operating under considerable uncertainty about

their future. The backdrop of organisational turbulence made for a challenging environment in which to build collaborative relationships. One health development manager described the HImP Group and the PCG as a whole as supportive organisations which would support individuals through very demanding times of organisational change. The importance of loyalty and trust within the PCG for fostering collaboration in an environment dominated by uncertainty was underlined by this City Council officer, amongst others.

> *I think it's a great group, because it's got energy, it gets things done. Out of necessity, it will change slightly [with the PCT move], and hopefully the dynamics of the people won't change the overall atmosphere. [HImP Group chair] is elected [to the PCT board] now, so ... hopefully she'll stay on as chair of the HImP group.* (City Council Officer: social inclusion)

5.4.2 PCT's Public Health and Inequalities (PH&I) group and 'patches'

The Public Health and Inequalities (PH&I) subgroup of the PCT replaced the PCG's HImP subgroup and took over its role in implementing the PCT's public health agenda. This section examines how the PH&I group's terms of reference, its composition, activity and character and its relationship to the rest of the PCG and the primary care community suited it to facilitating collaboration for health improvement.

PH&I group terms of reference

The PH&I group's terms of reference suggested that collaboration remained a prominent concern, but that it was more likely to be pursued within the NHS than with external agencies. Its stated aims included:

- *To develop a work plan to achieve this improvement in health in the context of the NHS Plan, the National Service Frameworks and other relevant NHS guidance.*

- *In partnership with others to work towards improving the health of the population of Oxford City PCT…*

- *To encourage primary care, community practitioners and the public to become involved and have ownership for work to improve health*

(PH&I Group Terms of Reference, 2001)

PH&I group composition

Initially, the PH&I group's composition was similar to that of the HImP group. The PCG HImP group's work was led by HDMs whose backgrounds were in community development in the voluntary sector, and its processes were inclusive of a diverse range of community groups whose work promoted health in its broadest sense, undertaking to *"involve all with an interest"* (PCG HImP group terms of reference). The jointly funded health development managers (HDMs) played key roles in collaboration between the PCG, the City Council and non-statutory organisations. They had proved themselves to be skilled networkers, committed to a bottom-up, locally-responsive and inclusive model of health improvement. However, the PCT's new approach to public health called for a different way of working and a restructuring of the public health function in line with the patch-based management structure. This arrangement was not well suited to the new responsibilities of the PH&I group and the group's composition changed significantly in the first six months. The PCT's PH&I group was more closely focussed on meeting national targets and priorities, which mostly were expressed in quantifiable, epidemiological terms. Government guidance stipulated that all PCTs were to appoint a Director of Public Health (DPH), a public health specialist who did not have to have a clinical background but, in most cases, had. In Oxford City, the DPH was supported by the appointment of three public health specialists - each of whom also had a medical background. The PCT inherited a fledgling public health team from the PCG which meant that it was recruiting to positions which overlapped with existing post-holders.

The restructuring of its public health function was protracted as the Faculty of Public Health's guidance on the appointment of PCT Directors of Public Health (DPH) was delayed, and the interim period resulted in considerable instability and uncertainty and disruption for the existing HImP team. It created

> *a difficult period to manage with some uncertainty for individuals and difficulties for outside agencies knowing who to talk to.* (PCT chief executive)

The health development managers, who had been in post for two and three years, applied for the posts but discovered the approach to health improvement they had been pursuing in the PCG was not what was required by the PCT.

At interview it was all about the medical model. Cervical cytology and immunisations. That's important as well, but it's the holistic, broad public health agenda that is so important and I hope it's not lost. (health development manager 2)

Another was told the PCT

"did not need partnership and collaboration skills" (Health development manager 2)

in the new postholders.

Within the first year of the PCT, the PCG's Health Development managers, whose roles were closely tied to the PCG's more locally determined, broad-based processes of health improvement, were both made redundant. The change in approach and the redundancies damaged many nascent partnerships.

PH&I group activity and character

The camaraderie and enthusiasm which the PH&I group inherited from the HImP group was undermined by the redundancies of the HDMs and the more managerial, less creative approach to health improvement.

The loss of two well-established members of the team was widely felt in a variety of ways. The HDMs and staff of other organisations they had built collaborations with expressed regret, anger, sadness and indignation that nascent partnerships or projects they had been working on would be damaged or abandoned. The comments of one HDM illustrate her personal commitment to the work and her sorrow at no longer being in a position to do it.

I will say, despite that fact that there's a tape recorder here, that I have been shocked at an organisation using redundancies in the first year of its existence. That shocked me. (PCG board/PCT PEC nurse)

The impact of losing their public health workers. At that meeting where we were told, you could see people were genuinely absolutely gutted that it had happened at every level. (City Council Officer: social inclusion)

The redundancies were also attributed to clashes of power and lack of trust within the PCT, where new individuals felt threatened by an established team. It was seen by some as a breach of the PCT's pledge to be an 'exemplary employer' and an organisation which valued its workforce.

It's more about a new organisation still stuck in the storming phase and developing and building trust. Internal trust. It's much more about that than anything external really. (health development manager 2)

Patches

The PCT's locality was divided into three "patches," primarily to facilitate the engagement of the primary care community in health improvement. Patches were designed to be of a scale which would strike a balance between considering the needs of the patient lists of individual, self-managed primary healthcare teams - the traditional horizon of GPs - and more strategic management of primary care activity at the whole PCT level. Each patch was allocated a public health specialist (these were not the PCG health development managers) and a patch manager whose broad remit was to encourage Primary Health Care Teams (PHCTs) to consider the health of a population that was wider than their own practice list. They would give individual teams the support and flexibility to look beyond their own practice's health improvement needs to those of a wider geographical area within the city and its population, and to collaborate with other PHCTs in order to meet them.

The way I do approve of the changes in the public health department here is that they aim to get much more patch-based and bring primary care workers into the public health discussion because in the end they're the people who have to implement it. You can't have everything done from outside. (PCT chief executive)

Health needs are always seen in terms of the practice responsibility, so everything's seen through the eyes of the practice. So deprivation and all that one's implying when one says that, is well understood by practices, but there's not a lot of sympathy between practice x and practice y who'll say 'yes, you must have some of my resources because I can see that your deprivation's...' (PCG board/ PCT PEC chair)

GPs are still very focussed on the needs of their practice. Now you could say that that is a public health dimension. They've got their identified population and they want to improve the health of that. Where we struggle always is saying this not about supporting the practice but a particular needy group or a particular geographical population. It's a very rare event to float away from your own

practice perspective and ignore all the years of thinking about your own population and spread it. I think that's quite difficult. (PCG board/ PCT PEC chair)

The chief executive's view reflected changes in the nature of health improvement. The PEC chair expressed the view that PHCTs did have an understanding of broad determinants of health, but did not have an organisational mechanism or incentives to act on it.

Patches were coterminous with pairs of the City Council's six newly formed Local Area Committees (LACs). Three City Council Area Co-ordinators each co-ordinated the work of two areas and were paired with the Patch Managers to facilitate collaboration. The City Council encouraged the PH&I group to be active in the Local Area Committee Meetings. Patch managers attended these meetings and could contribute from the floor, but had no formal position within them.

5.4.3 Collaborative relationships with non-statutory bodies

The health development managers, who were made redundant soon after the transition to PCT, had nurtured relationships between the PCG and non-statutory bodies which had not formerly engaged collaboratively with the NHS. Their redundancies, together with changes in the framework and style of health improvement, had implications for collaboration with these bodies. Some of the local organisations, agencies and practitioners who had originally contributed to the identification of the HImP priorities and the HImP stakeholders workshop felt cynical and betrayed as a result of the *volte face* of the health improvement process. The process they were originally invited to participate in was one where they could shape the agenda and directly influence the priorities. Their trust had been hard won by the HDMs over a period of time. This was subsequently sabotaged, from their point of view, by the fiercely top-down agenda driven by central government-prescribed priorities. Valuable partnerships that had been built at a grassroots level were perceived to be undermined by the more strategic, less organic approach to health improvement.

So certainly some of the work that [the health development managers] were involved in - it's just been decided that that's not appropriate any more... There were lots of links with community

> *groups, and that does seem like a big loss now. We all know that community development and community trust-building takes years and years and years, it doesn't just happen overnight.* (City Council Officer: social inclusion)

Those who had been instrumental in establishing this collaboration, most notably the HDMs, were deeply saddened that it was to be interrupted and brought to an end at a point when they felt they had made great progress towards building trust between themselves and these organisations.

> *I felt guilty at first. You build trust and I was making commitments and fully believed I'd be staying, but it's been taken out of my control. It does take a long time to build up partnerships and trust and understand people and know you believe in the same things, and we had really got there. A lot of debate, about issues and how they should be taken forward and I believed in it and enjoyed it.* (health development manager 2)

Summary: This section considered how the existence of these overarching locality-based structures facilitated primary care's adoption of a more collaborative, public health-oriented approach to health. It focused on the subgroups each established to implement the health improvement frameworks described in 5.3, and asked whether their composition and terms of reference enabled collaborative working for health improvement. It asked which individual and organisational factors facilitated and inhibited collaboration.

It argued that the PCG's coterminosity with the City Council supported a more strategic approach to tackling health inequalities than the fragmented primary care had previously, in particular the establishment of the subggroup to implement the health improvement frameworks. The group's terms of reference and composition facilitated an upstream approach to health improvement. The policy context in which the PCT operated was much less conducive to upstream health improvement than that of the PCG. Its obligation to meet medically-oriented health improvement targets identified by central government meant its health improvement working group's composition and terms of reference undermined the work of the PCG's health improvement group.

5.5 Practising clinicians elected by peers to governing bodies

The HImP group's Terms of Reference stated that it would encourage the ownership and involvement of primary care staff in work related to the HImP priorities. However, doctors' training is primarily medical with a focus on individual patients, rather than on broader determinants of the health of the population. Further, the primary care community was disparate and organisationally complex with little history of collaboration and a reputation for conservatism and resistance to change, so persuading them to adopt a new philosophy of health care was likely to be difficult. As chapter three showed, one mechanism by which they might be persuaded was the domination of the board by doctors and nurses who had been elected by their peers. If these clinicians endorsed health improvement work, this might lend it credibility and encourage their peers to adopt this new approach.

This section examines whether the presence of clinicians, elected by their peers, on the PCG board facilitated a corporate sense of ownership by PHCTs of health improvement work. Did the primary care community adopt a non-medical approach to health improvement which focussed on prevention and the broad determinants of health?

5.5.1 PCG board composition

Most of the clinicians on the board took little interest in the work of the HImP group. Over the period of the PCG's life, one of the board nurses was a consistent and active member of the HImP group. Two GPs were, consecutively, nominal members of the HImP group, but they were present at few meetings and both left within six months of the group being set up. The PCG chair, a GP, was sympathetic to the approach and philosophy of the group, but did not play an active role in its work.

No participants in the study reported having perceived a shift in primary care clinicians towards a stronger public health focus since the PCG came into being. They generally felt that individuals' tendencies to favour a public health over a medical approach would vary and was to some degree a matter of personal ideology: that there had always been people more and less interested in wider determinants of health - and that the PCG was not in a position to enforce the adoption of a different approach. At most, it could create, facilitate and publicise more opportunities for those who were interested in health

improvement initiatives to become involved in them. However, many argued that the plan to involve primary care professionals in the drive to reduce health inequalities, other than through the clinical roles in which they were trained, was misguided in itself: clinicians' capacity for this was limited by their role and training, and health improvement would be achieved more effectively through other means, such as the work of the Health Development managers in collaboration with local authority and voluntary bodies.

The City Council officer for health promotion doubted that the links he had built with senior members of the PCG would permeate throughout the PCG board, let alone the primary care community:

> *I think we've been very fortunate with someone like [the PCG chief executive] who's got a lot of vision and is prepared to do things differently, very flexible, innovative all the rest of it. If the agenda is about change, and I feel it needs to be, he subscribes to that agenda, and [PCG chair] as well ... But I guess I have a concern that although they are quite pioneering and so on, whether they'll be able to bring the board with them, whether there's enough carrots and sticks in the right proportions, I don't know.* (City Council Officer: health promotion)

Although the board tolerated HImP rather than endorsing it or giving it credibility with their peers, it did support it financially. Much of the cost involved in carrying out HImP work, especially around tackling substance misuse, was met from other PCG budgets such as those for service development, training and education and primary care staff. HImP activity was further supported financially by the PCG board: the HImP group was given a devolved budget (starting at £50,000 and rising to £60,000 over two years) to support particular projects relevant to the HImP priorities. In spending this budget the HImP group was accountable to the board. This funding contribution was made "..in order to ensure a real commitment to specific HImP priority projects, aimed at improving health in the broadest possible sense." (HImP Group Terms of Reference 1999). It was intended to support specific local health improvement projects in a number of ways, such as

> participatory needs assessment and project evaluation, project development and management, facilitation of primary health care staff involvement, facilitation of community members' involvement,

particularly excluded or vulnerable groups by, for example, community capacity building, project consultancy or research support (Primary Care Investment Plan 1999–2002, September 1999).

It was valued by members of the HImP group:

> Fortunately the board endorsed some money to go to project work, because that's where you get the innovation and the initiatives, especially in the partnership setting. We can do more – we can initiate more, we can work more in partnership with the voluntary sector, and the council. (health development manager 1)

However, beyond this budget, the PCG board took an 'arm's length' interest in the work of the HImP group. Whereas finance, prescribing and clinical governance were allocated an item on the agenda at each of the board's bi-monthly public meetings, the HImP group was allowed to present a brief report to the board only every six months. With the exception of the chief executive, the lay member and the board nurse who chaired the HImP group, the board themselves appeared to tolerate, but not fully understand, the HImP, and showed little enthusiasm for its work. The withdrawal of the GPs who originally had places on the HImP group reflected their declining interest in it.

Despite the intentions set out in the terms of reference, the HImP Group's formal connections to other parts of the PCG were not strong. Links with other sub-groups were not systematic but relied on members of one group being also members of another. Two members of the HImP group were also members of the Communications and Public Involvement Group (CPIG) but other than this, there was no overlap with other PCG subgroups.

This lack of connectedness with the PCG board and other parts of the organisation called into question the PCG's organisational readiness to encompass the work of the HImP Group into its mainstream business. One HDM felt that parts of the wider community were more receptive to the work of the HImP Group than was the rest of the PCG, and that it needed the PCG's support to lend it credibility.

> *It's all very well the HImP Group getting on and doing the work, but it needs the profile raised with the board. I would say outsiders probably know more than the board, which is often grappling with issues around clinical governance, or finances ... it would help to keep the profile up and for the PCG to be aware that things are*

happening and that these are valid issues to work on. (health development manager 1)

5.5.2 Clinicians on PCT PEC

Clinicians as PEC members, and lay domination of the board.

The governing bodies of the PCT were less medically dominated than those of the PCG. The PCT's board was dominated by lay people and managers, and the PEC had proportionally fewer GPs than the PCG board. This reduction of medical dominance may have presented an opportunity for public health, community development approaches to health to flourish. However, this opportunity was undermined by the increase in central government targets and performance management.

Influence on primary care community

In the PCT, the emphasis was taken away from collaboration with other organisations and was focussed on work to which primary care had a more obvious contribution to make, for example in vaccinations. Fieldwork for this study finished before any signs that the new patch structures were altering PHCTs' engagement with health improvement, but the change in nature of the aims of the work along more medical, quantifiable lines with which they were familiar, suggested they would be more able to engage in it.

PCT board's support of PH&I group

The PCT board supported the PH&I group by giving them a regular place on the agenda of board meetings. The work of the PH&I group had a higher profile with the governing bodies of the PCT compared with the PCG's level of interest in the HImP Group. It reported on progress against *NHS Plan* and national targets to the executive committee on a quarterly basis. This was significantly more frequent than the HImP group's annual report to the PCG board and implied greater levels of concern and interest on the part of the PCT.

Summary: This section examined whether the presence of clinicians, elected by their peers, on the PCG board facilitated a corporate sense of ownership by PHCTs of health improvement work. Did the primary care community adopt a non-medical approach to health improvement which focussed on prevention and the broad determinants of health?

It argued that although PCG approved the upstream HImP priorities and a ringfenced budget, its work was not prioritised by the PCG. The inclusion of clinicians on the governing bodies of the PCG and PCT did not lead clinicians on the governing bodies, or their constituent clinicians, to adopt a collaborative, public health-oriented approach to health improvement. Cultural barriers and doctors' individual and medically-oriented approach to health militated against this. The PCT's greater interest in the work of its health improvement subgroup did not equate to a more widespread interest in upstream health improvement since its approach to health improvement was more medically focussed on centrally-defined targets.

5.6 Local authority representation on governing bodies

As the PCG HImP group's terms of reference indicated, to meet its responsibility to improve the health of its local population, it would need to collaborate with organisations outwith the NHS, including the local authority. The Department of Health regarded SSD representation on the governing bodies of PCGs and PCTs as a potential mechanism to facilitate collaboration not only between the PCG and SSD, but also between primary care and the wider local authority (see section 3.2.2). This section examines how far representation of SSD on the governing bodies of the PCG and PCT proved to be an effective means of facilitating collaboration with local authority departments to improve the health of the population of Oxford. It also explores other mechanisms through which local authority departments collaborated with the PCG and PCT.

5.6.1 Concerns that SSD would dominate PCG-Local authority relationships

Local authorities' remits cover many areas which influence the broad social, environmental and economic determinants of health, yet SSDs were the only part of the local authority for which representation on the PCG board was mandatory. There were concerns that, rather than enhancing collaboration, the representation of SSDs on the PCG board would undermine collaboration between the PCG and other parts of the local authority. Early in the life of the

PCG, the same City Council officer, who had responsibility for health promotion, spoke of his expectation that the PCG would prioritise collaboration with the social services department and that relationships with the rest of the local authority would be sidelined. In his experience, health authorities related more easily to social services because they both provided items of service rather than more general functions. He feared that district council functions such as housing and environmental health, which played an important public health role and were of obvious relevance to the PCG's HImP priorities, ran the risk of being marginalised.

> *Social services are more about treatment than we are, and it's missing a trick isn't it? It's back to the broad determinants of health.* (City Council Officer: health promotion)

The feasibility of the SSD representation on the board as a mechanism for collaboration between primary care and local authority was compromised by the scale and complexity of local authority structures. Oxfordshire had a two-tier local authority in which Oxfordshire County Council provided certain services, including social services, to the whole county. Also, within Oxfordshire were six district councils, one of which was Oxford City Council, which had responsibility for services such as environmental health and housing. Oxfordshire County Council served the populations covered by six PCGs which were more-or-less coterminous with the district councils (although PCGs' boundaries were not defined geographically but by the patient lists of the PCGs' GP practices).

The potential for an SSD representative to constitute a mechanism for collaboration between a PCG and a local authority seemed small even in a unitary authority. It seemed less realistic still in a two-tiered local authority where county and district councils were separate.

The fears of the City Council officer that collaboration between the SSD and the PCG would overshadow collaborative opportunities between the PCG and other parts of the local authority were unfounded. In fact, the representation of SSD on the PCG board appeared neither to strengthen nor inhibit collaboration between the City Council and the PCG.

5.6.2 Local authority involvement in health improvement with PCG

There was evidence of good relationships between parts of the City Council and the PCG, independently of SSD representation on the PCG board. Although the City Council was not represented on the PCG's board, some strong threads of collaboration between the two organisations were established. Within Oxford City Council were departments whose titles suggested their work would relate closely to the PCG's health improvement duties, such as housing, environmental health and health promotion.

> *It doesn't feel like it's been a problem [for the health promotion department]. We're not on the board, but nevertheless we're still having an influence on the papers that are going to the board. They reflect some of the stuff we've been doing anyway.* (City Council Officer: health promotion)

The chief executive and chair of the PCG met twice a year with the chief executives, members and senior officers of Oxford City Council. Certain agreements, such as establishing the health development manager posts, were successfully negotiated between the PCG chief executive and the health promotion officer, a relatively low level City Council officer, then agreed by the Council Members and effectively 'rubber-stamped' by the City Council's chief executive. The chief executive took a largely 'hands-off' approach to engagement with the PCG, preferring to delegate it to others. Other than where funds had to be committed to a project, in his involvement in the Council's work with the PCG he generally remained at arm's length and delegated, rather than being closely involved himself, but this did not impede collaboration.

> *The only things that would really make a difference is when we would need to spend some money differently. For example, the funding for the joint posts we've done. But again they have mainly been negotiated between me and [PCG chief executive] then agreed by the members and then [City Council chief executive]'s just kind of known about it. That seems to work OK. There hasn't been a case yet where we've had to... There may be things in the future we may want to formalise agreements or something, and that may need the chief executive to sign it off.* (City Council Officer: health promotion)

> *I think definitely in any big hierarchical organisation, which we are, you need to have that stamp of approval from the top to make*

things happen... At the moment it feels to me as if things are working along OK. (City Council Officer: health promotion)

The housing department was much more distant from the City Council's chief executive. Its head officer was aware of interactions between the PCG and the City Council at board and chief executive level, but said no mechanisms were in place to translate that vertically into strategy at her (second-tier) level, or joint working at operational level. She described the group attended by the chief executive of the City Council and the PCGs as *"so strategic that no-one from housing actually goes to it."* Even as a second tier officer she felt far removed from it, was not informed of the frequency or agendas of meetings, or even whether the City Council chief executive attended them, and received no feedback.

I would say it [executive level meetings] has no impact on the staff delivering the service day to day in the Local Authority. I don't know what impact it may have on the GPs, but at a strategic level here, I've no idea of the frequency of the meetings, if [the City Council chief executive] actually bothers to attend or not. We have no idea what comes up on the agenda. We get no feedback from the meetings whatsoever. I have not a clue what is discussed if anything is. It's just like a blank. They've obviously established a contact at a strategic level, but as far as I'm aware there is nothing underneath that at all. (City Council Officer: housing)

Individual factors

Individual factors were key to the instigation and maintenance of collaboration. Where collaboration between the City Council and the PCG was most enthusiastically pursued, the influence of particular boundary-spanners was obvious. In particular, the City Council's Health Promotion officer provided energy, ideas, leadership and vision to instigate collaboration. He demonstrated an understanding of, and commitment to, collaboration which went beyond a ubiquitous keen but vague endorsement of collaboration as an aspirational ideal. He expressed an explicit, coherent conception of what health-related collaboration meant, and why it was important to the City Council. He recognised the public health underpinnings of many of the council's functions, for example housing, environment, workplace and recreation. He argued that elements of local government originated to protect

public health, and so their working with the PCG was an essential component of an effort to tackle health inequalities. He also believed that, to bring about collaboration between the two organisations to improve public health, awareness of the public health function of local government had to be raised across the City Council, and he saw this as a key element of his boundary-spanning role.

> *If you took most [city council] specialisms you could trace their origins to public health roots, and the problem is that we've sort of lost sight of that... Local Authorities have forgotten a bit of their raison d'être, and I'm sure a lot of my colleagues in this organisation don't see themselves as promoting public health. They see public health as a service not a function, so we've got a lot of work to do in reminding them. But while that's still the case, while it's still seen as 'oh health, that's [name]' or 'environmental health, they do health we don't' or 'we're planning, we don't do health' - they're unlikely to engage with the PCG.* (City Council Officer: health promotion)

He was able to articulate a coherent vision of the nature of health improving collaboration. The City Council's Health Promotion team had been involved in campaigns to encourage improvements in 'lifestyle issues' such as smoking cessation, healthy eating and accident prevention. He appreciated the value of such project work in that projects could sometimes grow into something more substantial. They were politically useful because they could have tangible results and draw the media's attention, but it was important that they didn't detract from the strategic goals of joint concern to both organisations. He felt that to make a more substantial impact on health, partnerships had to move from such marginalised joint projects and campaigns, to influencing those who wielded mainstream power and influence. He also anticipated some resistance to this.

> *The mainstream, looking at it quite cynically and brutally, was always very happy to let Health Promotion run around doing little campaigns and saying 'You must do this', 'you shouldn't do that', because it was never actually challenging the mainstream at all. To me it's much more powerful, more meaningful if that effort, which commandeers a tiny amount of resources in comparison to mainstream spending, actually starts to influence mainstream spending. 'How are we going to do this differently so we don't have*

to run this little campaign?' That's when things start to twitch and the mainstream power, money, influence starts to resist, to say 'Hang on - you're telling me that we're responsible for some of this poor health, or this impact on the environment? You're saying it's my fault? Why don't you go and run a little campaign?!' But only when we start to have those problems will we know we're actually making a difference (City Council Officer: health promotion)

He recognised that there were areas where the City Council could exert the most influence, such as transport, planning, housing and air quality. Through working collaboratively, he envisaged that greater influence could be exerted on these broad determinants of health, and health improvement could move from health promotion projects to more mainstream activity. The PCG would not necessarily be required to contribute a great deal of resources, but their collaborative value would sometimes be to offer credibility and solidarity in delivering the message. He saw the links with the PCG as beneficial in two ways. First, a joint identification of the areas for health improvement would more reliably prioritise the important issues than if organisations did so separately. Second, having identified the priority areas, a collaboration would be better placed to bring resources and influence to bear to bring about change than the organisations would individually. According to his vision, the role of the health development managers was systematically to challenge the health impact of each council department's work and encourage the delivery of the health improvement agenda through their mainstream spend, rather than through easily sidelined add-on projects. He saw their role as garnering support from primary care, applying their influence as leverage to the health improvement process.

> *In a way [health development manager]'s role will be to make a bit of a nuisance of herself, to help some of the work that we're doing so it's not just that bunch from Health Promotion saying we ought to improve the housing stock - it's actually GPs saying that as well, and with good reason.* (City Council Officer: health promotion)

Collaborative relationships between key boundary-spanners in the PCG and the City Council did not extensively permeate other areas of the local authority. As I have shown, relationships between the health promotion team and the PCG were strong, but this was not the only part of the authority whose work was relevant to the HImP priorities.

Housing was one of the five HImP priorities, yet links between the City Council's housing department and the PCG were minimal. The Head of Strategic Housing Services from Oxford City Council described close links between their department and social services at strategic and operational levels, but reported that these were quite independent of the PCG. Similarly, collaboration between members of the housing department and GP practices on an informal, *ad hoc* basis was well established, but she was aware of no impact that the PCG had had on these relationships. She was unaware that someone she knew well represented social services on the PCG board, and lamented the lack of collaboration between her department and the PCG.

> *We've got a lot of staff in housing services who we've employed for years and years, and lots of them live in Oxford, they've known the GPs for years and years. They get on well, they phone each other up, sort out problems. That works reasonably well, but I don't think the PCG has had an impact on that.* (City Council Officer: housing)

This contrast between the two parts of the City Council were mirrored in their respective relationships with the most senior ranks of their own organisation. The housing and environmental health departments reported quite different experiences of contact with their chief executive.

Organisational factors

The remarkable commitment to collaboration between parts of the City Council and the PCG was put down in part to organisational factors. The alliance was seen as politically acceptable with relatively low levels of risk. Collaboration was seen as a no-lose situation for two organisations with a similar ethos. The PCG constituted a city-based NHS structure which some City Council officers quickly identified as a potential partner in the development of its public health function. It was well-placed to work together strategically with the City Council to tackle the root causes of ill health in a way that the Health Authority had not been, due to the near-coterminosity of their boundaries. The PCG, being new, had no history of antagonism or conflict with other organisations. The collaborative rhetoric which surrounded it and its emphasis on health inequalities suggested it had the potential to follow a different approach to public health, and led to hope that it could shape things in a radically different way to what had gone before.

I think we've had a lot of success with the City Council. It was a very early alliance really, and colleagues in the City Council have been enormously committed to making it work, and have really worked very hard in their own organisation to push investment towards things that we wanted to see happen. I think we've been more successful with the city than we have with the county. It's been politically, if you like, a lot more acceptable. (PCG chief executive)

I think it works with the city because it's easy for the city. All politicians would like health to be more democratically tied in. It doesn't actually have to make any promises, as environmental health and housing can only benefit from being closer to health. There isn't a tension in the way there is with social services. So I just don't think the city can lose. And to their credit they've clocked that and they're exploiting that, and that's all to the good. I do think there's an ethos within the city PCG that chimes in with that.
(PCG/PCT lay member)

Funding cycles and procedures presented very real problems to partnership projects. The City Council's financial year did not match the timetable of social services or NHS bodies, and commitment to projects could not be made until all the necessary funding was in place.

It's a practical problem which, if the government is serious about promoting partnership working, really needs to be addressed. I know it's a real bureaucratic administrative detail, but it has to be sorted out. There's always going to be problems with partnership working while the budgetary timetables are not in synch. (City Council Officer: social inclusion)

The case of the City Council was further complicated by its structure which included elected members as well as officers. This brought both practical challenges in terms of an increased bureaucratic burden and longer times required to carry work forward, but also cultural challenges and vested interests which work against collaboration.

What you're saying is in effect, 'we want you to give up your little bit of power to make decisions on this area of the service and sort of pool it and all make decisions.' The people who are attracted to being politicians, it's because they want to wield power because they

enjoy it. In some ways they're the very worst people to say can you give it up for the common good. It's not just the members, there's quite a lot of officers that have a vested interest, and their jobs depend on them being the one that makes the decision. If they pass that over to a group, someone might point the finger and say 'What does that person do now? They don't have to make any of these strategic decisions now - do we need them?' (City Council Officer: housing)

5.6.3 Local authority involvement in PCT's health improvement

Section 5.4 described the PCG HImP subgroup's multidisciplinary and multisectoral composition and the strongly inclusive collaborative rhetoric of its terms of reference. Strong interpersonal relationships between members of the City Council and the PCG, along with their near coterminosity, underpinned strong collaborative relationships between the two organisations, built largely on the shared vision of a relatively small number of people at middle management level of each organisation, around priorities which were jointly identified.

This level of collaboration was not prioritised by the PCT. The chief executive of the PCT emphasised the importance of key individuals at the most senior strategic levels of the organisations to successful collaboration between them. She was one of four new senior appointments to the PCT and the City Council around the time of the inception of the PCT along with the PCT's Director of Public Health, the City Council's chief executive and its Director of Strategy. These senior individuals were quick to forge relationships and plan strategic collaboration. Meanwhile, restructuring of the City Council and the transition from PCG to PCT disrupted many of the collaborative relationships which had been built up by less senior officers in the two organisations over the previous two years.

The PCT chief executive conceded that the restructuring which resulted in the PCT's more senior links with the City Council may have disrupted the established collaborative arrangements built by the health development managers. She argued that this was overall a worthwhile change: the damage to previous collaborative relationships would be offset by the new structures which were to replace them to implement new, more strategic partnerships. She saw organisational change as a valuable opportunity to build new strategic

collaboration from the top-down. The strengthening of links at the most senior level in the two organisations was also recognised and welcomed by other Council officers:

> *We're in the process of getting quite a clear partnership agenda sorted out with the City Council. It feels a lot better than what we had before which was good relationships but a bit nebulous in terms of where we were going and what we were trying to achieve... We've got a joined-up view of what we want to achieve and it's a question of getting our teams in place to help deliver and implement that now, whereas I think beforehand we had the good working relationships on the ground but actually no sense of common direction.* (PCT chief executive)

> *I think maybe it will take a bit of time but maybe if patches can be the way to make public health more visible and more acceptable and more effective, then OK I'm prepared to invest a bit of refocusing and losing some of the other stuff to achieve that.* (PCG board/ PCT PEC chair)

> *Since our new chief executive came in 2001, again the links at chief executive level of the Primary Care Trust and our chief executive level have improved greatly* (City Council Officer: social inclusion)

The chief executives group continued, where the chief executives of the county PCTs and District Councils met to discuss strategy, although the outcomes were not fed down to middle-ranking officers:

> *There's this chief executives group which means the PCT goes and our chief executive goes. I'm just not sure that that then comes anywhere, and that we don't know what they're talking about, and whether there's work that we're then directed to do that comes out of that. I'm not sure that mechanism's in place yet.* (City Council Officer: social inclusion)

The boundaries of Oxford City PCT were the same as those of the PCG, so coterminosity with the City Council was not compromised. However, the interpersonal relationships which had developed between the PCG and the City Council were disrupted during the transition due to structural changes in both organisations, as well as to changes in policy emphasis represented by the *NHS Plan*.

The focus on centrally prescribed medical targets alienated the City Council officers who had previously been involved with the HImP. As issues prioritised by the HImP such as housing and homelessness, and substance misuse were displaced by the more medical priorities of the NHS Plan, it became more difficult for them to see the contribution they could make. Also, in the restructuring of the City Council, its health portfolio was removed, which brought into question the new leadership's commitment to health.

> *It's confusing for me now because we don't have a health improvement plan any more, so it feels like there isn't something we can go to and say 'our role in tackling health inequalities is put in the HImP and we know what it is.' The NHS Plan means nothing to anyone here. It's a bit like expecting the PCT to understand some of the plans that we produce like the local plan without any commentary or interpretation.* (City Council Officer: social inclusion)

> *One of the things that was noticeable for us with the restructure was that health did disappear. There was no portfolio given for health. ... The problem with this authority is that when the lawyers and the corporate people sit down and look at portfolios they think that health is something someone else does, and they don't give it a portfolio. Which is weird because they gave crime one and we don't go out and police the streets. I think that shows a difference between crime and health..* (City Council Officer: social inclusion)

Boundary-spanners had played an important role in the relationships between the PCG and the City Council. One of the key relationships between individuals from the City Council and the PCG was disrupted when the boundary-spanner from Health Promotion in the City Council and the HDMs who had formerly worked very closely together left their respective organisations. Their good working relationship and the City Councillor's particularly strong vision of, and commitment to tackling social, environmental and economic causes of health inequalities through collaboration were lost to both organisations. His skills as a boundary-spanner were also lost.

The officer's post was not continued when the City Council restructured. To some extent, his role was absorbed by the City Council's Director of Strategy, a more senior officer. However, this person had a much wider remit and was not

able to commit as much time and energy to the bridging role as his predecessor.

> *What's been weakened are the links between the lower or middle ranks of the council officers and the actual people who do the work at the PCT rather than director level.* (City Council Officer: social inclusion)

Wider organisational ownership of the health improvement agenda within the City Council remained elusive in the PCT era; by early 2003 there were no signs that this had been translated down the organisation or that members and officers were seeing their work in terms of improving health.

> *I still think people think health is about hospitals and that's what the PCT and doctors do and it's nothing to do with us. Of course we're the main housing authority, we clean the streets, we have a lot to do with environmental impact, issues about crime that affect health. But that message, I think, still doesn't really get there.* (City Council Officer: social inclusion)

A new link between the PCT and the City Council was the appointment of an elected member of the Council to the PCT board. Other board members reported that his presence on the board offered valuable insight into the mindset, culture and procedures of the council. However, his influence on the local authority's policies and practices were limited as a City Councillor in a two-tier local authority, as he was not in a position to affect collaboration with, for example, the SSD of the County Council. It was further reduced following local elections in which his party lost joint leadership of the council.

5.6.4 Change

With the publication of the *NHS Plan* it became clear that the HImP, and its approach, were to be shortlived. The *NHS Plan* heralded a different approach to public health, but the structures and processes which were to take its place remained uncertain for a number of months. This was unsettling for the Health Improvement subgroup and staff who knew their work and role would not continue as it had, but knew little about how or when it would change.

> *Not quite knowing what the new board will do or what commitment there's going to be from April, and the line management and the*

structure and where we all fit into that. Let's just hope it remains. We just wait and see. (health development manager 1)

The PCG staff were not anti-reform:

To push so that the change and modernisation happens - and it needs it, I'm not saying it's not needed, but to do it at a pace so that people don't feel burnt out... The atmosphere in the PCG is great, and that's what keeps you going really. So, as long as the local environment is friendly and conducive, it's all right (health development manager 2)

Collaborative relationships take time to establish trust and mutual understanding, to identify shared goals and values.

There's been an awful lot of groundwork that's needed to be done. If you look at what we've actually done differently it's not very much yet. In a sense that's inevitable - you've got to go through a lot of preparatory stuff. It's all very valuable - it'll have spin-offs later. The fact is we've gone along to these meetings, no-one has put their foot in anything untoward, we haven't disagreed violently over anything yet. And that will all bear fruit later on. I think fairly soon we're going to come under pressure to say OK what are you going to do that's different now? And that's always the challenge with these things. (City Council Officer: health promotion)

Organisational change is a force frequently cited as an impediment to building good partnerships. From the point of view of one City Council officer the opportunities presented by the introduction of a city-based PCG outweighed the secondary impediments caused by the upheaval of staff. Another was less prepared to accept its benefits until they were proved:

I think that a lot of people are quite cynical about it. Fundholding was meant to be the answer to everything and it wasn't highly successful and I think people think PCGs are just the same. An administrative detail to make it look as if something's happened, that it's all dynamic but it's not really. (City Council Officer: housing)

Conclusion: This section examined how far representation of SSD on the governing bodies of the PCG and PCT proved to be an effective means of facilitating collaboration with local authority departments to improve the

health of the population of Oxford. It also explored other mechanisms through which local authority departments collaborated with the PCG and PCT.

It argued that SSD representation on the board was not the root of the health improvement-related collaboration which developed between some departments of the City Council and the PCG through the efforts of a small number of boundary-spanners from the PCG and the city council.

5.7 Summary

This section returns to the third research question set out in section 3.7 and draws conclusions about how it can be answered in the light of data from chapter five.

RQ3 How far did the following features of PCGs' and PCTs' organisational forms allow them to bring about a collaborative approach to improving the health of their population?

- their explicit health improvement remit
- its locality-wide base
- the election of practising clinicians to their governing bodies
- the representation of the local authority's SSD on their governing bodies

Health improvement remit

The PCG's explicit health improvement remit fostered a more collaborative, upstream approach to health than had traditionally been taken in primary care. The PCT also was given health improvement responsibilities, but these were undermined by the context in which it operated. This context was a much more hierarchical mode of governance, in which medically-focused problems, identified by central government, were prioritised over complex social issues.

What excited many people about the introduction of the PCG was that, for the first time, work to promote public health and prevent ill health was endorsed and legitimised through the organisation's explicit health improvement remit. Central government's role was facilitative, encouraging priorities to be identified locally and PCGs were given a free rein to adopt a bottom-up

approach to work with other local organisations to identify local health improvement priorities. Oxford City PCG rose to this challenge eagerly and adopted a collaborative and outward-looking approach to health improvement which was very new for primary care. It prioritised complex, non-medical, social problems in its Health Improvement Programme (HImP) and inclusive, collaborative relationships evolved among a range of actors who identified shared interests in addressing these priorities in a bottom-up way. The PCG's progress was assessed in terms of proxy measures for long term public health outcomes. Ownership of the HImP was high amongst those carrying out the work, and members of the HImP group were personally very committed to it. The group's structures were flexible and informal, and they carried out their work through locally-driven, bottom-up processes.

The cross-cutting nature of their HImP priorities meant they relied heavily on boundary-spanners. The group's two most active members were the health development managers (HDMs), whose posts were jointly funded by the PCG and the City Council. The PCG was coterminous with the City Council, many of whose functions derived from public health origins. Their professional backgrounds were in community development and health promotion, and they were adept at working in inclusive, collaborative ways and employing upstream approaches to health improvement. The sense of camaraderie and commitment within the HImP group was remarkable. They played key roles in collaboration between the PCG, the City Council and non-statutory organisations. They proved themselves to be skilled networkers, committed to a bottom-up, locally-responsive and inclusive model of health improvement. This was in keeping with New Labour's rhetoric of collaboration and the imperative to tackle complex social problems.

The rhetoric of improving health survived the transition from PCG to PCT, as PCTs were also explicitly charged with a public health function and a Director of Public Health was appointed. However, the publication of the *NHS Plan* in 2000 brought centrally-defined targets to the fore. These deflected attention from the local HImP priorities and were perceived by many to conflict in detail, ethos and philosophy, with the locally responsive, bottom-up health improvement of the HImP.

Over time, the PCT almost completely discarded the PCG's locally identified HImP priorities and instead its Health Improvement and Modernisation Plan

(HIMP) directed their work towards priority areas set out by central government. Many of the trusting, collaborative relationships which had been developed between local bodies and primary care under the auspices of the PCG were badly damaged.

The redundancies of the two HDMs was seen as controversial, and undermined the network relationships they had developed. When interviewed for the new public health specialist posts, the HDMs were told their collaborative skills would not be required in the PCT, and they were replaced with medically trained public health specialists. Collaborative relationships between the HImP group and non-statutory bodies were badly damaged by redundancies of the HDMs. In good faith they had made promises which they were unable to keep because they were no longer in post. This proved very damaging to the trust which had been carefully nurtured over two years. Many research participants felt an unacceptable opportunity cost was attached to the increasingly medical orientation of the health improvement agenda.

Most of the new areas of work were considerably more medically-focussed than the PCG's HImP priorities had been. The PH&I group were asked to report on progress regularly to the PCT board, and the PCT was more closely performance managed upwards by the strategic health authority against targets set by central government. The performance management was more formal in style and the targets were strictly quantifiable.

Locality-based primary care organisation

The locality-wide base of PCG/Ts had potential to facilitate collaboration for upstream health improvement, but was not in itself sufficient. When the context was conducive to the fostering of network relationships in the PCG based on loyalty and reciprocity, it was facilitatory. However, during the PCT's first year, the context became one which encouraged contract-like relationships rather than networks.

The introduction of a locality-wide primary care organisation provided an opportunity to set up city-wide working groups, one of which was the HImP group.

The HImP subgroup was set up by the PCG board to take forward its health improvement work, in collaboration with a range of other local organisations. Its terms of reference were resolutely outward-looking and indicated an approach to carrying forward health improvement which challenged primary care's history of isolation from other organisations, particularly from those outside of the NHS, and was in keeping with the collaborative rhetoric of the third way.

The working group (PH&I group) required to implement the PCT's health improvement agenda differed from the HImP group. The contrasts between the two subgroups reflected some of the key differences between the policy contexts within which the PCG and the PCT operated. The PH&I group's composition and terms of reference were shaped by centrally-driven forces driving an increasingly medically-defined public health agenda for primary care.

The PCT's approach to public health led to the restructuring of the public health function in line with patch-based management structure. The PEC argued that to divide the PCT area into three 'patches' was a more feasible scale than city-wide on which to pursue collaboratively the *NHS Plan* targets. That patches were coterminous with City Council 'local area committees' indicated that intentions to collaborate with the local authority to address non-medical determinants of health had not been altogether abandoned in favour of a return to an emphasis on clinical targets. The fieldwork for this study was completed before the effectiveness of this approach to facilitating collaboration within primary care or between primary care and the City Council was in evidence. However, it was clear that the drive towards a collaborative, bottom-up approach to health improvement which tackled the broad determinants of health was making way for a more traditionally medical approach, less resonant of networks as in New Labour's early rhetoric.

Clinicians on governing bodies

The election of clinicians to the governing bodies of the PCG/T was not an effective mechanism to bring about a collaborative, upstream approach to health improvement. The PCG HImP group operated in parallel, and separately from, mainstream primary care activity. GP membership of the HImP group was too shortlived to influence GPs' medically-oriented culture. Clinicians were

more involved with the PCT's public health and inequalities work because it was better aligned to their practice.

The HImP was a low profile element of the PCG's agenda.Initially the HImP group's membership included two GPs. The board endorsed the HImP priorities and a ringfenced HImP budget. This suggested the group might challenge general practitioners' individual, medically-oriented approach to health, as well as the organisational and cultural barriers between them and other group members and the animosity between health professionals and health service managers. However, within the first six months the GPs had left the group. Rather than challenging the culture of general practice, the HImP group worked in parallel with it with a stronger public health orientation. The PCG's remit to improve health did not persuade primary care practitioners to shift their own practice away from a medically, individually focussed one. The HImP process did not require that GPs relinquish any autonomy, status or power, or that they themselves established any new collaborative relationships.

Other than this, however, board clinician involvement in the HImP process was minimal: they maintained an arm's length relationship to the HImP, setting up a dedicated working group which it supported financially but taking little interest in its methods or achievements. The PCG board did not allow the HImP group to report regularly at board meetings as they did other working groups.

The medical, individually-focussed approach of clinicians was not directly challenged by the HImP.

The PCG's HImP work appeared to be treated as an add-on to the main work of the PCG's board, which was led by managers and impinged little on their working lives or those of their clinician colleagues. However, the animosity which characterised many professional-manager relationships was not evident in this case. These professional-manager relationships were characterised more by detachment and disinterest than by outright hostility.

The PCT's approach to public health and inequalities, driven by more medical targets, was more readily understood by doctors, and so there was more collaboration towards its goals from PEC clinicians themselves. Whereas the PCG's HImP was not perceived to be relevant to most clinicians' day to day work, the implementation of the HIMP and the *NHS Plan* had much more direct

relevance to their practice, because their professional roles were more closely aligned to treatment of the prioritised conditions. PCT PEC members were more involved in strategy for health improvement than they had been in the PCG.

The distinction between health improvement and clinical governance was less distinct in the PCT than it had been in the PCG. Thus, clinicians were expected to play a greater part in health improvement, but it was to be in a form which fitted more readily with their traditional professional culture.

SSD representative on board

SSD representation on the governing bodies of the PCG/T was not effective as a mechanism to facilitate health improvement work between primary care and the local authority, because the local authority was two-tier, the county council was not coterminous with the PCG and the SSD representative was not a practitioner as were other board members. Boundary-spanners operated independently of the board to engender collaboration between the PCG and some, but not all, departments of the City Council. Reliance on these boundary-spanners made the collaborative relationships vulnerable to organisational change.

Second, boundary-spanners within the city council did not allow their lack of direct representation on the PCG board to impede collaboration. Strong collaborative relationships between the PCG and parts of the city council were established and maintained by a small number of key boundary-spanners. Two effective boundary-spanners, the PCG chief executive and an officer from the city council, negotiated the joint funding of two HDM posts. The two HDMs, in turn, had strong boundary-spanning roles. This city council officer saw the burgeoning relationship with the PCG as an opportunity to reconnect the city council with its public health roots.

Coterminosity between the City Council and the PCG worked in the favour of boundary-spanners. However, other organisational factors meant that collaboration between the PCG and all parts of the City Council was far from automatic. The city council was big, and the collaboration was not sufficiently strategic to avoid collaborative gaps. Organisational and structural barriers remained. Too great a reliance on boundary-spanners meant that where collaboration worked it worked well, but several departments, for example housing, remained disconnected from the PCG.

In the PCT, these collaborative relationships, which depended on individuals, were disrupted by redundancies and organisational change.

Chapter six: Primary care development and delivery

6.1 Overview

This chapter is the second of three findings chapters which examine the PCG's and PCT's collaborative capacity and practice, the third element identified in the realist theoretical framework.

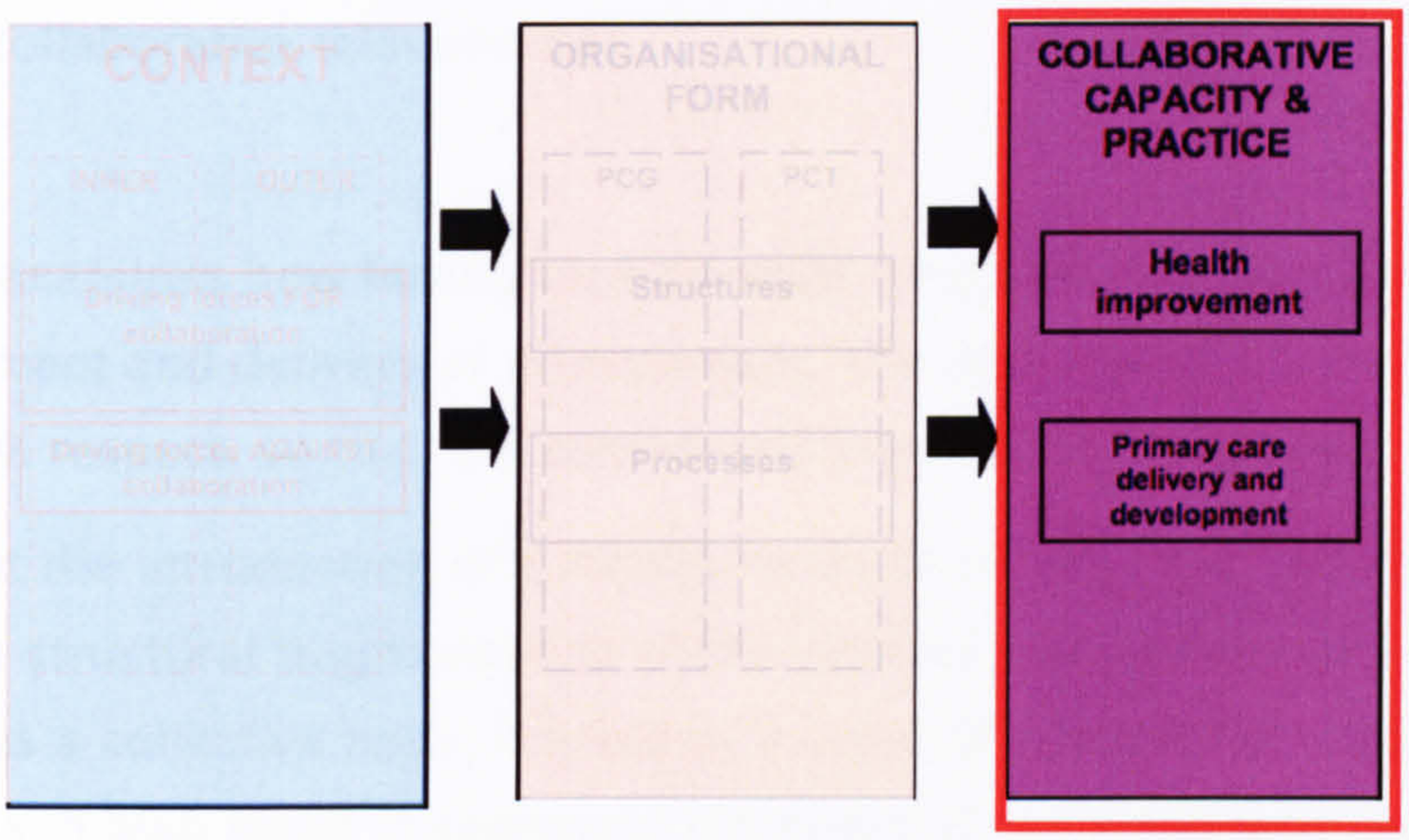

Figure 8: Realist theoretical framework – collaborative capacity

As chapter three set out, PCGs and PCTs had responsibility for developing and delivering primary care. They were expected to assure the quality as well as contain the cost of primary care services. This chapter addresses research question 4 (see p80) which draws on the analytical framework (figure 6) to identify four features of the organisations' forms which were likely to facilitate collaboration.

RQ4: How far did the following features of PCGs' and PCTs' organisational forms equip them to develop a sense of corporacy and collaboration within the primary care community to develop and deliver primary care?

- their locality-wide base
- the election of practising clinicians to their governing bodies
- their budgetary and clinical governance responsibilities
- the inclusion of a local authority social services department (SSD) representative on their governing bodies.

It asks whether these features – which were common to both the PCG and the PCT but manifest differently in each – equipped them to bring about a more collaborative, corporate approach to the delivery and development of primary care in the city. It draws on interview data to illuminate the experiences and perspectives of participants from different professional groups, from the PCG and PCT and from the wider primary care community, as well as from participants whose main work lay outside the NHS. It also uses documentary and observational evidence. Through these data, it explores how the elements of the context identified in the framework in figure 6 helped and hindered the building of collaborative relationships.

Section 6.2 examines how having locality-wide structures in place facilitated the development and delivery of primary care. The PCG and PCT were broadly similar in this respect, so they are considered together in his section.

It argues that the introduction of a locality-wide body, the PCG, reduced the considerable structural fragmentation of the primary care community in several ways. First, as a collective body, it acted as a point of contact for collaborating organisations. It also acted to represent members of the previously disparate primary care community to some extent, although consensus between the city's clinicians did not automatically follow from this structural change. As a collective body, the PCT was less conspicuous than the PCT, largely because it had been preceded by the PCG and so departed less radically from what had gone before. Its extended sphere of responsibility relative to the PCG, and particularly its responsibility to implement more centrally-defined policies, meant it was a more bureaucratic and less locally responsive organisation.

Second, the PCG and PCT convened working groups which brought together clinicians and managers to develop primary care, to implement clinical governance on a locality-wide basis, and to develop training and education for health and social care staff. It also published a local newsletter for local clinicians and other health-related bodies. Third, GP forums brought together local GPs in new ways which aimed to erode fragmentation and encourage a sense of unity between them, although this was of limited success. Fourth, the PCT became the employer of community nurses which, some anticipated, would challenge the status differentials between nurses and other professionals in the primary care community, although there was little evidence that this was the case.

Section 6.3 examines whether the PCG's and PCT's clinician-led governing bodies nurtured a sense of corporacy: whether these structures enabled local clinicians to feed into, and feel ownership of, policy and, therefore, to be motivated to comply with it. It considers the PCG and PCT separately because clinicians occupied different positions within their quite different organisational structures. It draws a distinction between the roles of clinicians on governing bodies as strategists and as representatives of the clinicians who elected them.

It argues that their strengths as strategists were seen to lie in their identity as practitioners, and their consequent closeness to local issues and to patients. Their weaknesses were seen to be their lack of experience of working strategically with other organisations. On balance, local clinicians were very supportive of this aspect of the PCG model. The shift of clinicians from board to professional executive committee (PEC) in the PCT did not curtail the effectiveness of the clinician-as-strategist model. However, the PCT's greater preoccupation with nationally-defined targets limited their efficacy as strategists.

As well as their strategic roles, clinician board members were seen to have a representative function. Community and practice nurses were cautiously optimistic that because clinicians sat on its board, the PCG could act as a vehicle for developing a shared identity and sense of purpose within primary care locally. However, this optimism was tempered by previous experiences of feeling powerless at the policy table, as well as by the employment status of practice nurses which served to exclude them partially from the PCG's processes. Its effectiveness as a means of involving nurses in the collective activity of the primary care community was indeed limited partly by the fact that nurses were outnumbered by doctors on the board, which perpetuated existing power differentials. Although the imbalance in numbers of GPs and nurses was reduced in the PCT, by then the enthusiasm of nurses to become involved had waned and there was little interest amongst nurses in joining the PEC. This was reflected in the paucity of applicants for the greater number of nurse positions on the PCT PEC.

Amongst GPs, other than ex-fundholders, the representation of GPs on the PCG board by their peers was popular. The increased organisational complexity of the PCT compared to the PCG, and the PCT's increased obligation to act on

national priorities, weakened the sense of representative-ness of GPs. However, the continuity of GP representatives from PCG to PCT was one of the few elements of continuity between the two organisations.

Section 6.4 examines the budgetary and clinical governance activities in the PCG and PCT, and the extent to which they transformed the primary care community from a fragmented one which lacked co-ordination, to one with a sense of collective responsibility. It focuses on how the new primary care development and delivery responsibilities were interpreted by the PCG and PCT: how their priorities were identified; how clinical governance and financial strategies were devised to deliver more coherent primary care services; and how progress was assessed against them. In these respects, the approaches of the two organisations differed little and so they are considered together in this section.

It argues that the employment and professional status of GPs as independent contractors placed considerable limitations on the PCG's influence over their clinical practice and its capacity to nurture a sense of cohesion. The PCG recognised this and, as a result, its primary care development priorities were identified through inclusive and facilitative, rather than authoritarian, means, since this was considered to be a more effective way to bring about changes in GPs' clinical practice. The board GPs played a major role in the development of prescribing and clinical governance policy and, as a result, practices complied with it more readily than they would have had it been imposed by managers. Their progress in priority areas was assessed in ways which encouraged them to improve relative to their peers, rather than in ways that would expose practices which had not made good progress.

This section also examines clinicians' views on the PCG and PCT as vehicles for developing a shared identity and sense of purpose within primary care locally, and on the implications of it for facilitating collective activity in the primary care community. It examines the implications of changes in commissioning arrangements; of clinicians' limited experience of management and collaboration; and of the professional and employment status of GPs, for cohesion. Finally, it examines the two organisations' approaches to planning, education and training.

It argues that many factors of national policy militated against the development of a shared sense of identity and purpose across a primary care community. Dismantling what GP fundholding there had been in Oxford was

controversial since the levelling up of services was not always compatible with overall budgetary constraints. Although the inclusion of clinicians on governing bodies was largely seen as positive, their presence on the PCG board and PCT PEC did not necessarily make difficult decisions less unpopular. Finally, it argues that the PCG/T approaches to planning, and the provision of education and training open to a range of clinicians and local authority staff, were conducive to collaboration within and beyond the primary care community.

Section 6.5 explores the role of the SSD member on the governing bodies of the PCG and PCT and whether it allowed primary care to develop in ways which took into account the perspectives of both health and social care.

It argues that SSD representation on the PCG board was considered to be of very limited effectiveness. It depended heavily on individuals who were not always available. It was argued that the PCG prioritised establishing itself as an organisation, and was medically dominated, and that these factors impeded collaboration with social services. Geographical boundaries and different internal structures and financial pressures also presented challenges for collaboration.

Collaboration between the PCT and SSD promised to be more strategic and with higher level oversight.

Section 6.6 summarises the findings about the PCG's and PCT's collaborative activity to develop and deliver primary care. It assesses the differences between the two organisations' approaches and relates them to the contextual factors of the framework in **section 3.7.**

The overall argument of this chapter is that factors such as the power and status differentials between different professional groups, and the history of little collaboration in general practice, could be overcome to some extent by structural factors such as the introduction of locality-wide organisations and the inclusion of clinicians on their governing bodies. However, they are resistant to change, and structural factors are not in themselves always sufficient to overcome cultural barriers to collaboration.

6.2 Locality-wide primary care organisation

The introduction of Oxford City PCG and PCT meant that, for the first time, there was a locality-based primary care organisation in the city. This contrasted with the previous fragmentation of primary care and independence of general practice. This section considers how the existence of these overarching primary care structures facilitated the delivery and development of primary care in the city. The PCG and PCT were broadly similar in this respect, so they are considered together in this section.

6.2.1 Point of contact

The very existence of an overarching primary care organisation for Oxford City provided external organisations with a point of contact with primary care citywide which had previously been lacking. It was helpful to agencies which needed to work with the primary care community in the city that they could now work with a single body rather than trying to negotiate with each practice individually. For example, a social services manager who experienced difficulties in establishing access to primary care services for asylum seekers was able to approach the PCG to help resolve this problem. Prior to its introduction, she would have had either to contact practices individually or to work through Oxfordshire Health Authority which had a less local focus. The PCG, in contrast, was building a relationship with each practice in the city and had a mandate and resources to address such problems on a strategic city-wide basis.

Similarly, as the local Drug Action Team formulated its action plan, it approached the PCG to enquire about the needs, views and priorities of the local primary care community. The PCG's substance misuse service development officer was able to report on the needs of the practices within the PCG on the basis of a consultation he had undertaken, which included a survey of all GPs in the city and a workshop which had been attended by a range of stakeholders.

Of course, the PCG's existence did not guarantee a consensus within the primary care community on every issue, and mechanisms for consultation were not always perceived to be adequate. Some clinicians objected to the notion that a manager from the PCG should speak on their behalf. However, a recognisable primary care body was in place, and its relationship with its

constituents evolved over time as budgetary and clinical governance arrangements developed.

Whereas the PCG was formed in a context where previously there had been no collective primary care organisation in the locality, the PCT was established in a context in which the primary care community had become habituated to the existence of a local primary care organisation.

The PCT had a greater budget and greater responsibilities, which lent it, as a representative body, more power in its negotiations with secondary care and other organisations. However, the PCT's more complex, bureaucratic structure meant it was perceived as less unified than the PCG as well as less focussed on, and responsive to, local issues. Its greater organisational complexity brought about a diminished sense of corporacy and greater distance between the PCT and the primary care community. This is explored further in section 6.4 about the role of practising clinicians on the governing bodies of PCGs and PCTs.

6.2.2 Working groups

The Primary Care Development Group (PCDG) was formed as a working group of the PCG board to develop primary care collaboratively with practitioners in the city. It was made up of clinicians, practice managers and PCG development staff. It was responsible for leading a number of processes to develop primary care in the city, including the "Future Directions" consultation (see 6.3). A subgroup of the PCDG was the Education and Training Group which organised multidisciplinary education and training for health and social care staff. A Clinical Governance working group was also convened. Clinical governance was prioritised by the PCG: its was the only subgroup which was invited to report to each board meeting.

These groups continued their work in a similar way as subgroups of both the PCG and PCT. The PCT strengthened the PCG's multidisciplinary training and education program, and introduced 'protected learning time,' where all practices in the city were encouraged to close for a day or half day to come together for joint training. It continued and developed the PCG's clinical governance work, maintained the GP and nurses forums and the PCT newsletter.

The remits of these groups are discussed further in 6.3

6.2.3 Nurse and GP forums

Prior to the establishment of the PCG, the Community Health Trust (CHT) had instigated nurse forum meetings which were held monthly for all community health nurses, including district nurses, health visitors and practice nurses. At these meetings, nurses discussed both clinical and organisational issues and, following the establishment of the PCG, feedback was presented to the PCG. Whereas full-time CHT nurses were contractually obliged to attend seven such meetings each year, the status of practice nurses as employees of GPs meant it could be difficult for them to take time out of the practice to attend them.

Prior to the PCG, little was in place to create a sense of collective identity for GPs in Oxford. Oxfordshire had a countywide Local Medical Committee, but no equivalent city-wide fora were in place to facilitate communication between GPs in different practices, or between GPs and the PCG. Practices operated independently of one another, coming together occasionally for training and education but little else.

The PCG chair identified a need for a local doctors' forum, to "inform strategy, to hear about grassroots problems, to share information and to make sure we are using everyone's skills" (PCG chair, 2000). It was some time from the introduction of the PCG in April 1999 until its first meeting in January 2001. The forum met thereafter every six to eight weeks, with half of each meeting open to items from GPs and the other half reserved for pre-determined PCG-led topics. Small project groups were also set up, with defined tasks and timescales, and their recommendations were fed back to the Primary Care Development subgroup of the board. They dealt with specific clinical areas, particularly those around the primary-secondary interface, as well as non-clinical areas.

As there was no obligation on GPs to attend, the numbers who did depended largely on the topic under discussion. These forums would generally attract only a few (up to 15) GPs, but occasionally, when the topic was of great interest to GPs, usually because it had resource or workload implications such as out-of-hours services, the turnout was much greater (around 70).

6.2.4 PCT employment of community nurses

When PCGs were replaced by PCTs, CHTs were disbanded and the employment of their staff transferred to PCTs. One GP anticipated that this would be an

opportunity to reduce the power differential between nurses and doctors. He perceived that the employment practices of the CHT, which required they clock in and clock out, undermined their professionalism. This, he felt, perpetuated the status and power differentials between GPs and nurses, and thus impeded collaboration between the two groups. He hoped that their employment by the PCT would address the two professional groups' inequalities in status and allow them greater autonomy.

> *They have to fill in time sheets. I mean are they grown up or what? I think it's an insult that district nurses and health visitors are treated in that way by their employers. They're not being treated like professionals. So if the PCT can achieve a demolition of that sort of culture and a new culture where we all work in the same direction and we all have the same professional values I think that's fantastic.* (GP 2)

However, the impact of the PCT's employment of community nurses was less significant than this doctor had anticipated. Community nurses retained their employee status while GPs, for the most part, remained independent contractors. I found no indication that the PCT did, in fact, challenge the status differentials between the two professional groups.

Summary: This section considered how the existence of these overarching primary care structures facilitated the delivery and development of primary care in the city. The PCG and PCT were broadly similar in this respect, so they were considered together in this section.

It argued that as a collective body, the PCG acted as a point of contact for collaborating organisations as well as to represent the primary care community (although this structural change did not automatically lead to consensus). The PCT's responsibility to implement more centrally-defined policies meant it was more bureaucratic and less locally responsive. The organisations' working groups brought together clinicians and managers to develop primary care, to implement clinical governance on a locality-wide basis, and to develop training and education for health and social care staff. Their GP forums brought together local GPs in new ways which aimed to erode fragmentation and encourage a sense of unity between them, although this was of limited success. As the employer of community nurses, there was little evidence that PCT challenged the status differentials between nurses and other professionals in the primary care community.

6.3 Practising clinicians elected by peers to governing bodies

It was argued in chapter three that a sense of corporacy would need to be engendered between clinicians, and between clinicians and management for the primary care community to fulfil its primary care development responsibilities. They had, together, to develop budgetary and clinical governance policy which was acceptable to clinicians, and to implement it. GPs would have to be encouraged to collaborate in pursuit of the collective interests of primary care across the city. Given GPs' history of autonomy, self-regulation, their continuing status as independent contractors, and the traditional animosity between them and health service managers, heavy-handed managerial tactics to force them to practice differently were unlikely to be effective.

As chapter three showed, the PCG model bypassed, to some extent, the clinician-manager tensions by including primary care practitioners on their governing bodies. On these bodies, the clinicians had both strategic and representative roles. This section examines the implications of the clinician-led governing bodies for the development of strategy and nurturing a sense of corporacy by enabling their clinicians to feed into, and feel ownership of policy and, therefore, to be motivated to comply with it.

It considers the PCG and PCT separately because clinicians occupied different positions within these two quite different structures.

6.3.1 Practising clinicians on PCG board

Clinicians as strategists

Most board members were supportive of the model of the primary care group governing board, believing that practitioners' closeness to practice placed them well to contribute to policies to develop primary care. This board nurse argued that the PCG's greatest strength lay in the contribution practitioners made to the board's decision-making, as they were in touch with patients and the front line of delivery of primary care.

> *What all of us [board clinicians] bring to the work is that experience of practice contact with patients every day, and I would never sacrifice*

that, personally, because I think that's what enriches my whole way of looking. I've never gone into nurse management because I want to keep client contact. I think that's what the white paper [New NHS] was trying to recognise, one of the very first places I've seen for years talking about the involvement of community practitioners. I very much value that dual thing. I think it enriches both. (PCG board/PCT PEC nurse)

Board members held that the mix of clinicians on the board fostered debates in which the different professional groups were exposed to each other's cultures, concerns and styles of working, and that this provided a valuable learning opportunity for them all.

Undoubtedly having nurses working together with doctors in that way has brought nursing issues much closer to the doctors. They saw things happening before, but they didn't perhaps consider them in quite the same way. (health visitor 2)

Arguments against the inclusion of clinicians on the board were that practitioners lacked experience of working strategically with other organisations. Some saw clinical skills as being entirely different from strategic and managerial skills, and argued competence in one area does not imply competence in the other. For example, a primary care development nurse from the Community Health Trust (CHT) argued that the PCG model was ill-conceived and not at all well suited to collaborative working. Although nurses and doctors on the board would certainly have experience of collaborative working with other clinicians and SSD care managers in managing the care of individual patients, they would not bring to the board the strategic insight that comes from the experience of managing large services. Through this experience, she argued:

..one learns about the very, very, very alien culture the Local Authorities have, which is completely different from the Health Service culture... They're [PCG board doctors and nurses] unlikely to have a picture of what the political sensitivities are, which ways you need to go in to get the outcome and to influence practice the way you want to. (CHT Community Development Nurse)

Might she have had reason for her misgivings? They were shared by a senior member of SSD staff who had no direct connection to the PCG, but who felt similarly that clinician and managerial skills were distinct:

> *Leave your professionals to get on with their professional expertise. I think clearly you need a board with accountability and a board with the professional expertise, but at the end of the day, running an organisation is an expertise in itself. It's different from providing a service.* (SSD Manager 1)

The uncertainties surrounding the future positions of CHT primary care development nurses provide a crucial factor of context in which their views should be understood. The positions of nurse managers from the CHT seemed more precarious than anyone's given the imminent dissolution of the CHT, and so the managerial position of the PCG nurse board members could be seen as a trespass on their professional territory. The PCG model offered community nurses strategic influence that they had not previously had, so its perpetuation was in their interests. PCG board nurses did lack the PCDNs' experience of collaboration at a strategic level. However, as the next section shows, the principle that places on the PCG board were occupied by practising clinicians had the strong support of their constituent clinicians. This was seen by them to outweigh their lack of experience of strategic planning.

Only one PCG board member was an ex-GP fundholder. He felt his strategic skills were underused by the PCG. Through developing services for their practices, GP fundholding practices had developed skills in designing, commissioning, developing and implementing services for their patients which he felt would have been valuable to the PCG. This GP resigned his position on the board partly through frustration that he was not given the opportunity to exercise these skills in the PCG as he would have liked to. Services were developed more slowly and less efficiently than he thought they would have had the PCG exploited the experience and skills of ex-fundholders.

> *That's what fundholders did - had consultation and developed new services. And did it fast.* (PCG board GP1)

Clinicians as representatives

Here I examine clinicians' views on the principle, as well as the quality and accessibility of board representation, their inclination to assume a role in the local primary care policy process and the effects of their employment status on this. Did their representation on the board by elected peers persuade clinicians to see the PCG as a vehicle for developing a shared identity and sense of

purpose within primary care locally? Did it have implications for facilitating collective activity in the primary care community?

Accessibility and quality

Not all GPs felt the population of the PCG's governing board by clinicians worked as a means to bring together the clinicians in the city. The ex-fundholding GP who was a PCG board member described how other GPs' attitudes to him had been unduly negative and that indeed, far from feeling part of a new, cohesive primary care community, the introduction of the PCG left him feeling marginalised and discriminated against on the grounds that he had been a fundholder:

> *It doesn't seem to me that the other GPs in Oxford did anything other than be anti-fundholding. The PCG is largely democratic and largely representative of the anti-fundholding, and being identified as closely as we are with pro-fundholding views, that is quite difficult... It feels divisive.* (PCG board GP1)

All the community nurses interviewed held their board representatives in very high esteem and reported that they found them accessible; all but one of the eight nurses interviewed knew their names and how to contact them. They were unanimously in favour of the principle and practice of being represented at this strategic level by elected local practitioners. They valued the fact that these were their peers: familiar, accessible, 'one-of-us' and in touch with current local issues. The representatives were also valued as individuals, and the nurses interviewed were confident that through them their views and interests were represented fairly and well.

> *I always think with [name of board nurse] she's got her hands on so she knows what's happening at the grassroots level as well as looking at the way forward. It makes a good balance. Sometimes I think people get a bit too distanced from what actually happens. So I think it actually works quite well.* (district nurse 3)

The board nurses themselves were reportedly determined in their efforts to involve the wider nursing community in the work of the PCG.

> *She really pushes, you know, she almost sort of bullies: 'You've got to let me know what you want to say'* (district nurse 2)

However, community nurses' perceived capacity to contribute to the PCG's work was influenced by the context in which the board operated. Nurses described three main limitations: their workload pressures, the PCG's communication style, and a lack of confidence that nurses' views would be taken seriously enough to influence local policy.

The PCG board nurse representatives generally had a slot, or were at least present, at their respective nurse forum meetings. Pressing caseloads sometimes prevented nurses attending however, leaving some feeling out of touch. The board's business was disseminated via written bulletins and newsletters but again, their volume and the pressure of time on the nurses meant they were not always effective means of communication. In its newsletter, the PCG expressed its commitment to encouraging the participation of nurses in its work by keeping them informed of developments and involving them in its decisions. It circulated details of nurses' forum meetings to all city nurses, and of a training and education programme. The PCG website and newsletter each had a nurses' section. When interviewed, community nurses (CNs) and practice nurses (PNs) agreed that the information sent to them was abundant, but often they were critical of the PCG's methods and style of communication.

> *We get loads [of written communication from the PCG]. I don't read them all. It's far too much, it's jargonistic, we all get individual copies, which I think is a ludicrous waste of money, but yes, we get it! We are informed!* (District nurse 2)

The PCG presented a new opportunity for nurses to exercise strategic influence over the direction of primary care at the locality level. Some were excited by this and felt they and their colleagues had a responsibility to grasp it. They were unsympathetic towards nurses who complained that they were uninformed of changes when they had made no effort to be involved, and felt the burden of responsibility fell too often on a few individuals.

Others expressed weariness at more "new opportunities" to engage in organisational reform which, they felt, lacked substance. Three nurses referred to their profession's lack of confidence in its influence. One health visitor explained this in terms of the Community Nursing Forum's history of marginal influence. It had failed to resolve issues relating to the CHT, even though community nursing was the major part of the CHT's business. She feared that

their concerns would assume less importance still within the PCG and their sense of powerlessness would be compounded.

> *In terms of nurses having a voice I think it's our responsibility to make the noises and let them know what our concerns are... and I just think that perhaps we're not doing that enough. That we're happy to sit and complain about things that aren't changing, but we're still not yet into the culture of thinking 'I can actually do something about this.' We're perhaps not used to being listened to, or taken seriously...* (district nurse 4)

> *I feel a little bit far removed from it I suppose. It's been another year, we've seen a hundred and five changes, that kind of thing, and ... I suppose I have often put in an enormous amount of energy to try and go along with those changes to find that they're changing back anyway, so I'm slightly cynical.* (health visitor 1)

> *Perhaps our priorities will be sitting somewhere near the bottom which is maybe how it has to be.* (health visitor 3)

Employment status

Practice nurses faced particular challenges in engaging with the PCG process because of their status as employees of GPs rather than of the CHT. In theory they had access to meetings from which their issues and concerns would be fed on, through the nurse representatives, to the PCG board. But as employees of GPs, their first contractual duty was to the practice, and they were aware of the financial impact on the practice that their absence would have.

> *I feel pretty bad because I haven't been to them [meetings]. Because I'm employed by the GPs, my priority is that I see the patients because the GPs employ me to do that... I find that a real struggle.* (practice nurse)

Overall, the first year of the PCG could be characterised as a period in which new opportunities to develop a sense of shared purpose and unity amongst community and practice nurses emerged. In principle these were broadly welcomed by the nursing community and, on the face of it, the organisational structure and the commitment of the board nurses were in place to facilitate this. However, the influence of the context on implementation was evident. Rapid organisational change and the relatively low status of the nursing profession meant some nurses were ambivalent towards the new organisation

and their opportunity, through it, to exploit the opportunities it claimed to present for them to shape the provision of primary care.

In terms of developing the sense of commitment to and ownership of the PCG's collaborative process identified by Hardy et al (2000) as ingredients of successful partnerships, the value attached by nurses to being represented by 'their own' was clear. Board nurses had won the confidence of their electorate, and they were considered familiar, trustworthy, accessible and in touch with issues and the community.

However, it is not evident that this confidence in their elected representatives led to active 'buy-in' from the practitioner community. After 18 months, the outcomes of nurse representation in terms of its impact on nurses' day-to-day working lives were intangible.

> *I think initially that feeling of hope was: 'OK, we've got something new and exciting happening', and some people may feel that that is the case. I may be wrong but I think quite a lot of nurses have continued doing their work without being terribly aware of an awful lot that was happening.* (health visitor 2)

6.3.2 Practising clinicians on PCT professional executive committee (PEC)

As Chapter 3 set out, the inclusion of practitioners on the PCG/T governing bodies was intended to influence its work in two related ways: first, by eliciting the input of practitioners to policy and strategy and, second, by introducing a sense of cohesion and ownership to the primary care community. The clinicians-as-strategists model was heartily welcomed in principle by the practitioners in the community, (although some nurses doubted that, in practice, it strengthened their strategic influence). However, there was little direct involvement of community practitioners other than board members in the work of any subgroups, although some GPs were involved in the development of substance misuse services. There was, therefore, potential for further community input to PCT policy and strategy.

Clinicians as strategists

As a result of the separation of the board from the PEC, and the larger bureaucratic scale of the PCT compared to the PCG, some GPs reported that it felt more distant from them than the PCG had. The more complex structure of the PCT brought ambiguity of power and status and appeared to shift it from

clinicians towards lay people and managers. In the PCG, strategic decisions were taken by a board composed mainly of clinicians, whereas in the PCT these were shared between two governing bodies, only one of which was dominated by clinicians. Further, the most senior level of the PCG comprised the GP chair and the lay chief executive; a clinician:manager ratio of 1:1. The PCT was led by "three at the top": the chief executive (lay), the board chair (lay) and the executive committee chair (GP), reducing this clinician:manager ratio to 1:2. It became less clear to the practitioners on the PEC, and to their colleagues in the community, that they were able to influence policy and its implementation.

They questioned whether the move from PCG board to PCT PEC was a demotion of clinicians from 'driving seat' (DH, 1997: para 5.1) to passenger seat. It was perceived, at first, to represent a shift in the power base of the clinicians which put influence back in the hands of managers and bureaucrats, undermining the clinician-led model of the PCG. It was unclear how power and influence would be distributed between the two bodies and through the organisation as a whole. There was a concern that it would mean clinicians had less overall influence over local issues, particularly in a context in which central government was exerting greater influence than ever over the way NHS services were delivered through more centralised policy making and performance management.

The imbalance between the number of GPs and nurses on the PCT was reduced compared to the PCG. Paradoxically, the transition to PCT appeared, in some respects, to lessen the preparedness or capacity of nurses in the community to assume a strategic role in guiding the direction of the primary care community. Community nurses' reduced engagement in the business of the PCT compared to the PCG was manifest in their lack of involvement in subgroups and the difficulties in recruiting nurse PEC members. The increase in the number of nurse places on the PCT PEC, together with the maternity leave of one of the PCG board nurses, meant vacancies came up on the PEC for two nurses. There was little interest in them, and the paucity of candidates for these vacancies indicated that interest in the PCT was low amongst nurses.

Chapter three suggested that the employment of community nurses by the PCT might bring about more cohesive packages of primary and social care. However, the transfer of their employment had little impact on their collaboration with social care staff.

I think they've [nurses and care managers] always worked quite closely together anyway. I'm not sure the PCT has taken that another step forward. I don't think it's been a great sea change as a result of the PCT taking them on. (PCG board/ PCT PEC chair)

Clinicians as representatives

The separation of the board from the PEC in the PCT muddied the mechanism for clinician representation and introduced doubts about clinicians' influence on policy. In order for the clinicians on the PEC to act effectively as conduits between their constituent clinicians and policy, they had both to be in touch with their constituents and be influential in the policy process. The clinician–PEC link in the chain appeared to be intact: the PEC GP chair felt that relationships between the PEC and the city's GPs were good – they felt in touch with their opinions through being a part of, and accessible to, the GP community. However, he acknowledged that their influence on policy sometimes seemed questionable to the GPs in the city. Another PEC GP revealed that he too was unsure that they were influential.

I think in general we're probably not seen as remote because we're always at the meetings and all this sort of thing, so they see us. But in terms of making their feelings change the organisation then the links are so many and so long that they probably don't have confidence. (PCG board/ PCT PEC chair)

It may be there's a disconnection – that there's no connection between me and what actually happens in the organisation. I'd like to think there is, but maybe I'm just window dressing and the whole of the executive committee is just window dressing, and that's the sort of nightmare that I tend to have. I know that's not the case because we are steering policy. (PCG board/PCT PEC GP)

This indirect chain of influence from clinician to PCT policy resulted partly from the separation of the PEC from the board and its more bureaucratic and less transparent processes. This brought with it a number of disadvantages. First, there were felt to be gaps in communication and understanding between the two bodies, despite the element of overlap between them. Second, whereas the PCG board met in public (as did the PCT board), the PCT PEC met in private, so the clinicians' decision-making process was no longer exposed to the scrutiny of their peers or the public.

The risks at that stage must have been incredibly high of it all going off the rails, and there was a honeymoon period probably where GPs, and nurses to a different extent, felt that it was going to be the same as the PCG with knobs on, more functionalities. Then reality began to hit with things like starter budgets and lack of money coming out to primary care, and the national targets coming down, and that's made GPs particularly feel less and less nailed in, and therefore quicker to criticise and therefore more of an uphill battle to involve... (PCG board/ PCT PEC chair)

However, as the new organisation established itself, concerns that clinicians' influence had been eroded by the new organisation subsided, and practitioners on the PEC found they were still in a position to influence the major decisions made in the PCT.

I think some of the clinicians who have previously been on the board in the early days felt they weren't where the action was. I suspect they now realise that's not the case because the action's in the Executive. (PCG/PCT lay member)

As one nurse anticipated (see 6.4.1), community nurses' employment by the PCT seemed to do little to bring their concerns to prominence on the PCT's agenda. Community nursing had represented a large proportion of the CHT's activity and their interests were relatively high profile within it. In contrast, the PCT's agenda was crowded with many other issues, and community nurses felt their issues were sidelined. Despite the PEC nurse representatives' efforts to rally their colleagues in the city, they felt less influential in the larger PCT than they had been in the CHT, and workloads continued to present a barrier to their colleagues' engagement.

In the PCT community nursing is - well, I was going to say a drop in the bucket. I think that might be how it feels to community nurses. It may not be the intention, but it is how it feels, and I think most people get on with their clinical work and have not as much engagement with the PCT as I would like. I don't think it's for want of trying to communicate and engage people. But the agendas are heavy, workloads are heavy. (PCG board/PCT PEC nurse)

Still, the PCT management recognised that the PCT had to make greater effort to involve the broader primary care community in policy making. It was

difficult for clinicians on the governing body to represent the diversity of their constituents' views and to reconcile their preferences with the sometimes difficult options available. The PCT attempted to broaden the direct participation of the primary care community by increasing their opportunities to join the subgroups of the PEC, such as the Secondary Care Access Group, the Primary Care Development Group, Clinical Governance, Education and Training.

> *I think what you get through the executive committee is a clinical reality and a clinical perspective. I think it's very hard for members of the executive committee to say they can represent the views of their colleagues. Their colleagues invariably have a hundred and one different viewpoints, and will support the nice things and challenge the difficult things...*
>
> *We're trying to not see the executive committee as the sole place where we get clinicians from the city involved in decision making and working with the PCT. We've tried to widen that net, to increase the number of people who come into the building and talk to us and get involved in the work we're doing. (PCT chief executive)*

Continuity

There was a strong degree of continuity of membership between the PCG board and the PCT PEC of doctor and, to a lesser extent, nurse representation. This meant the relationships which had originated in the PCG between the elected clinicians and their constituents were maintained in the PCT. It offered some stability amidst much organisational change, and limited the disruption to the trust and loyalty built between them as governing body members, and between them and their constituent clinicians. It also built upon the experience as strategists these clinicians had developed in the PCG. The PCT aimed to extend the collaborative reach of the PCT by including pharmacy and therapist representatives on the PEC alongside the nurses and GPs. Also, the imbalance in numbers of nurses and GPs was reduced compared to the PCG: another partial challenge to the imbalances of power and status between doctors and nurses.

Summary: This section examined the implications of the clinician-led governing bodies for the development of strategy and nurturing a sense of

corporacy by enabling their clinicians to feed into, and feel ownership of policy and, therefore, to be motivated to comply with it.

It argued that the PCG board members were seen to have strategic and representative roles. Their strengths as strategists were seen to lie in their identity as practitioners, and their weaknesses in their lack of experience of working strategically with other organisations. The influence of nationally-defined targets limited their efficacy as strategists on the PCT compared to the PCG. The continuity of GP representatives from PCG to PCT was one of the few elements of continuity between the two organisations. The effectiveness of nurse representation as a means of involving their peers in the collective activity of the primary care community was indeed limited partly by the fact that nurses were outnumbered by doctors on the board, which perpetuated existing power differentials and rendered PCT PEC membership less attractive to nurses.

6.4 Shared responsibilities and corporate behaviour in primary care

Chapter three described the fragmentation and lack of co-ordination of primary care services prior to the introduction of PCGs. General practitioners were independent contractors who provided services for their own patient list. Community nurses were sometimes attached to a single practice or a small number of practices but - other than practice nurses - had been employed by their local CHT. To instil a sense of collective responsibility to a primary care community for the delivery and development of services was an ambitious objective.

PCGs and PCTs had to pull together these previously disparate and uncoordinated constituents of the primary care community to develop and deliver more coherent primary care services. They had to develop policies on budgetary issues, clinical governance, education and training and planning of services and set them out annually in the form of their Primary Care Investment Plan.

PCGs and PCTs had responsibility to implement clinical governance, the local framework for monitoring and improving the quality of services. Thus, they had to shape and constrain spending and clinical behaviour in the local primary care community. They were also given a unified budget, calculated to cover the cost of all NHS healthcare for all patients on the PCG's and PCT's practice lists. This meant GP fundholding had to be dismantled, priorities for spending had to be agreed across the locality, and clinicians persuaded to practice within the constraints it implied. Implementing clinical governance and the unified budget required new corporate behaviour within the PCG and PCT, particularly amongst GPs whose practice and clinical decision-making had the greatest cost implications.

This section examines the budgetary and clinical governance developments in the PCG and PCT. It focuses on how the new primary care development and delivery responsibilities were interpreted by the PCG and PCT: how their priorities were identified, how clinical governance and financial strategies were devised by each, and how progress was assessed against them.

It section also examines clinicians' views on the PCG and PCT as vehicles for developing a shared identity and sense of purpose within primary care locally, and the implications of it for facilitating collective activity in the primary care community. It examines the implications for cohesion first of changes in commissioning arrangements; second, of clinicians' limited experience of management and collaboration; and third, of the professional and employment status of GPs. Finally, it examines the two organisations' approaches tp planning, education and training.

In these respects, the two organisations differed little: the PCT largely adopted the processes and continued the approach which the PCG had set up, making no significant changes.

6.4.1 Budget and clinical governance

Transition from GP fundholding to PCG

Chapter two postulated that certain contextual factors were likely to bear on GPs' perspectives on the introduction of the PCG and their readiness to take part in collective activity with the primary care community, or to adopt a corporate identity as part of it. These were their professional status relative to other primary care professionals; their autonomy and employment status as

independent contractors; the local history of commissioning secondary services; their limited experience of NHS management and of collaboration with other organisations (including other practices, local authority and non-statutory organisations); animosity between professionals and managers; and their predominantly individual, medical approach to healthcare. These largely militated against the development of a sense of cohesion and common purpose amongst GPs in the city, and between GPs and the wider primary care community. Their influence on the introduction of the PCG and the dismantling of fundholding are examined here.

GP fundholding (GPFH) had demonstrated that GPs and groups of GPs could, to some extent, effectively manage a budget to provide and commission cost-effective care. However, GPFH perpetuated variations in the standards of care patients received. PCG and PCT models were designed to universalise budgetary aspects of GPFH such that a locality-based group of clinicians was given responsibility for managing a budget to cover healthcare for all their patients, and for implementing local systems to ensure the quality of this care.

In Oxford the take-up of GP fundholding and other forms of primary care commissioning prior to the PCG had been low. In some parts of the country, GP fundholding had become the dominant model. In other areas, GPs ideologically opposed to bringing the principles of the marketplace into the NHS had adopted alternative forms of GP commissioning such as total purchasing pilots. These meant practices had gained experience of collaborating with one another to commission secondary services and developed, to some extent, a collective identity as a commissioning body. In Oxford, however, no alternative joint commissioning arrangements had been established.

Still, dismantling what fundholding activity there had been in Oxford was controversial, and painful for some ex-fundholders, as they had to forgo some of their freedom to develop services independently of other practices. PCGs were to ensure that provision of services was equitable across all practices in the locality. It required sensitive budgetary manoeuvres, in particular, in reviewing the provision of particular services in primary care.

Some services had been provided by a minority of practices under GP fundholding, and the PCG had to decide whether and how it would continue to fund them. This was controversial since practices which had provided a service prior to the PCG did not want to lose it. Further, central government rhetoric was of "levelling up" not "levelling down" i.e. ensuring that services developed

by fundholders were made available across the locality, rather than reducing standards of care available to any patients.

Having GPs on the board of the PCG was expected to make the transition more palatable for these GPs since decisions about service development and resource allocation would be made by their peers, with whom they shared professional values and identity, rather than NHS managers who, as chapter two set out, often operated from a different set of principles and perspectives. Physiotherapy, for example, had been provided in practice by four former fundholding practices. To provide physiotherapy in every practice would have had significant cost implications, but after a protracted period of negotiation between the PCG board and GPs in the community, a compromise was reached whereby physiotherapy services were provided from some practices in the city, but could be accessed by patients from other practices. Levelling up also occurred with counselling and psychology services, which were made available to practices across the city, many of which had not previously had access to them.

Levelling up, however, was not always seen by the PCG as a viable option, given their inevitably limited resources. While the PCG supported and reorganised some services which had been developed in practices under the fundholding system, others were not subsequently funded by the PCG. In some cases, this led to animosity towards the PCG which was seen as the cause of damage to the quality of service provision. The unpopularity of a difficult decision was not automatically mitigated by the fact that it had been made by a clinician-led body.

Clinical governance issues

Clinical governance focussed mainly on issues concerning GPs' practice. A large proportion of the PCG's single cash-limited budget was spent on prescription drugs. This meant that effective and cost-effective prescribing practice was a high priority and ongoing issue for clinical governance.

As chapter three showed, clinical governance and budgetary constraints risked being viewed as an unwelcome intrusion on the self-regulation of GPs. The PCG ultimately could decide whether or not it would fund services such as physiotherapy, but there were other areas of doctors' practice over which they had little direct control. Most GPs operated as independent contractors, which meant they were not accountable on a day-to-day basis to any form of

management. While some practices had a practice manager, this was an employee of the practice who would manage the practice rather than manage the GPs, and the practice manager would be accountable to the GPs rather than vice versa. As long as the majority of GPs remained independent contractors, the PCG's power to exert leverage and impose change on most aspects of their clinical and prescribing practice was limited, so the PCG had to develop an approach to clinical governance which was acceptable to GPs, and with which they would consent to comply.

Both the PCG and PCT in Oxford City employed inclusive and facilitative rather than authoritarian clinical governance procedures, so doctors were encouraged to view it positively and to collaborate with their peers to shape its direction. Clinical governance priorities were identified through consultation with practices, which led the PCG to adopt coronary heart disease and mental health as two issues around which service improvements, good practice and techniques for monitoring performance were developed. An annual clinical governance report was published and in June 2000 a clinical governance conference was called for practices to share examples of their good practice and experiences. With the publication of the *NHS Plan* (Secretary of State for Health, 2000) priority areas for service delivery were specified centrally which guided the development of clinical governance, although the PCG's priorities fitted well with these so relatively little disruption was caused.

Although GPs' prescribing spends had not previously been regulated, targets were set for each practice. A formula which allowed for the effects of deprivation levels and other demographics on practices' spends was developed by board GPs and agreed by the board. Anonymised graphs were produced which allowed each practice to compare its performance to other practices' against these targets. The combination of the clinician-generated approach to prescribing policy and implementation, the provision of guidance on prescribing generic drugs, and the support of a prescribing advisor was effective: practices in the PCG did comply with PCG policy and collectively reduce their spending on prescribing.

6.4.2 Planning, education and training

The PCG was keen to involve local clinicians in the day-to-day issues of clinical governance as well as more long-term, strategic service development. The city's whole primary care community was invited by the PCG to contribute to a

one-day consultation called: *Future Directions; The Development of Primary Care in Oxford City,* at which the whole range of primary care workers was asked to think creatively about the direction for primary care in Oxford over the medium term: what it should provide and how it should be delivered over the following ten years. This attracted primary care professionals from across the city, across disciplines and professional groups, and brought them together to share ideas, perspectives and points of view on a city-wide scale in a way that had not happened prior to the PCG.

The PCG developed a training programme, linked to clinical governance, which covered a range of issues from specific practice skills, such as wound care, to more abstract levels of professional development, such as multidisciplinary working. It was made available not only to primary care workers, but also to social care staff. New opportunities for joint training opened up by the PCG provided further chances for practitioners to learn and solve problems together.

> *Suddenly we're able to tap into this other source of training, and particularly on promoting independence. So yes, there's extra training opportunities for people from social services and health, which is great, because I like the cross-fertilisation of ideas.* (SSD Care Manager 2)

Conclusion: This section examined the budgetary and clinical governance developments in the PCG and PCT. It argued that the professional and employment status of doctors meant that controlling their clinical and budgetary practice was challenging for the PCG/T. Introducing the structure of the PCG was not in itself sufficient to overcome these challenges. However, the fact that board GPs were influential in shaping clinical governance, and that the PCG took a facilitatory, rather than a coercive, approach to its implementation, meant that doctors complied with it to a great extent.

6.5 Local authority representation on governing bodies

The Social Ser vices Department (SSD) of the local authority was represented on the governing bodies of the PCG and PCT. This section explores the role of the

SSD member on the governing bodies of the PCG and PCT and whether it allowed primary care to develop in ways which took into account the perspectives of both health and social care.

6.5.1 SSD representation on PCG board

Reluctant collaboration

Sensitivities around social services' contribution to the PCG were high, and the language used when the issue was raised in interview reflected discomfort in discussing it. It was impeded by the SSD representative's absence due to sickness for several months soon after the PCG went 'live'. Most participants from outside of the SSD acknowledged that collaboration between primary care and the SSD was unforthcoming, but were reluctant to discuss reasons for this lack of progress on record. Asked whether she thought there was potential for more input from social service to the PCG, one board nurse's response was:

> *It's key. It's absolutely key, and it's just been an unfortunate set of circumstances. I'm not saying anything more than that on the tape... I was pleased at the commitment to send a high level - the deputies to the director - but that hasn't really worked in the city, for whatever reasons, and I regret that. You can't deliver the HImP agenda without that, and I think you can't really improve primary care in isolation from social care. So I'm hoping that will pick up.* (PCG board/PCT PEC nurse)

When she was asked about the level of influence social services had had in shaping the PCG's work, one social services manager's response was quite defensive:

> *I think I will answer that by saying that social services takes its commitment to PCGs very seriously, and that's demonstrated by the fact that representation on PCG boards is at assistant director level. And they're putting a huge amount of energy and time into all PCGs.* (SSD Manager 1)

A number of suggestions were made, off the record and unattributably, to explain the reluctant collaboration between the PCG and social services. One was that it was at least in part a result of the medical dominance of the PCG agenda and its preoccupation with establishing and developing itself and its finances, and that other concerns, such as social services involvement, had

been squeezed off the agenda, and the important contribution they could make to the delivery of primary care services had been overlooked.

> *I think probably the feeling from where we're coming from is that there are such huge agendas within PCGs that actually there's things that need to be sorted out that's actually not pertinent to social services at this stage.* (SSD Manager 2)

Others felt that responsibility for social services' lack of involvement rested with social services; that their input to the business of the PCG had been invited but was not forthcoming due to pressures and their prioritisation of other things within their department. Other circumstances intervened to inhibit collaboration. For example, a reorganisation of the SSD at the assistant director level took place at the same time as a radical change in the delivery of social services was heralded by the publication of *Modernising Social Services* (Secretary of State for Health, 1998). Further, this all took place against a backdrop of serious financial difficulties.

Structural and geographical boundary differences between NHS and local authority

The organisational structures of primary care and social services were very different. Whereas primary care professionals were mostly generalists whose skills could be applied across the community within certain parameters, social services are more specialised and are organised in "silos" of management and accountability. This made it difficult to pitch the SSD board representative at a level of strategic influence equivalent the board doctors and nurses who were all practicing clinicians. The social services department was part of the county council of a two-tier local authority, and covered five PCG areas. Initially, the decision was taken to allocate one assistant director to each of these five PCGs, and to signal commitment to collaboration at a senior level, that PCGs were being taken seriously by social services. This set the social services representative apart from the doctors and nurses in terms of their current hands-on understanding of operational and strategic matters.

Oxford City PCG's social services representative had a remit for adult services. Health professionals who worked closely with children's services expressed concerns that they might be disadvantaged or marginalised by the PCG's focus on older people and the social services representative's adult remit.

> *Just like primary care teams don't all easily relate to the PCG, and some are much more closely attached than others, social services is a very disparate organisation and there is one very senior manager from social services on the PCO, but she's from adult services and she won't really be able to tell you anything much about children's services.* (SSD Manager 1)

Accountability mechanisms between the two organisations were unclear, and there was no obvious mechanism for action via the social services representative in either direction between the PCG and the wider local authority. The potential for the PCG to use its link with the SSD to tap into local democratic function of the local authority was not realised.

For a time, prompted in part by the absence through sickness of the board representative, a Service Manager was co-opted to the PCG board and attended some sub-group meetings. Her position in the hierarchy was the next level down from the Assistant Manager, with some operational responsibilities. Social services research participants anticipated that her lower position in the hierarchy would mean she could bring an understanding of operational issues faced by frontline social services staff, would be better placed to share information with her colleagues, and her position would be more consistent with the health practitioners on the board, while still being sufficiently senior to effect change.

> *I think it has been welcomed by development managers of each of the PCGs and I think that'll be a very fruitful way forward of making sure the right services are commissioned locally.* (Joint Investment Plan co-ordinator)

However the capacity of the co-opted Service Manager to effect change across the SSD was limited and, while her involvement led to some useful work around relatively circumscribed issues such as co-ordinating social and health services for asylum seekers, no wider effects were identified. There appeared to be a trade-off between having a sufficiently senior representative able to link at a strategic level across a broader section of the organisation, and a less senior one with close access to a narrower section of social services staff at a practitioner level. There would appear to be scope for input from both assistant director and service manager levels, although this was not realised in the PCG for any sustained period.

Geographical boundaries were another factor identified by social services staff as a barrier to the collaboration between the five Oxfordshire PCGs and Oxfordshire's social services department. While the benefits in terms of responsiveness to local needs of a geographically small PCG was acknowledged, one Care Manager described how each of the five city or district-based PCGs had its own quirks or idiosyncrasies were difficult for social services to accommodate. These differences were reflected in the Health Improvement Programme priorities identified by each PCG, and they conflicted with social services' need for a level of countywide consistency.

> *"[PCGs] see themselves as pioneers and... each area seems to have things that they are ranking as very important. It might be asylum seekers in one area, it might be healthcare for older people, something to do with cancer somewhere else, service delivery somewhere else... Surely if we're going to have consistency there's got to be core things that each PCG should be taking on board, and then bringing it together and having more of a focus so that you actually develop in a similar way... Otherwise it's going to be a mish-mash and we won't be as effective as we could.* (SSD Care Manager 1)

Financial pressures

The wider economic context had a bearing on social services' capacity for collaboration. Financial pressures were also identified as a significant barrier to building collaboration at strategic and practitioner level in a context in which the SSD was chronically underfunded and Health Act flexibilities had not been widely employed to pool budgets. Funding structures and charging legislation set by central government, which the PCG had no power to change, presented obstacles. The SSD's state of chronic underfunding had rendered them less psychologically equipped to be open to working with other organisations.

> *Certainly my view is that people retreat into their corner when they're under pressure, and I think part of the pressure that's around all this for social services is not just about finance, but the consequences of not having finance for so long that staff have been moved around in different roles, reorganisation, all that stuff that happens, and I just think that they're a bit short on energy.* (PCG/PCT lay member)

6.5.2 SSD representation on the PCT PEC

The expectations of the PCT were higher than of the PCG to collaborate with social services. PCTs were tasked with 'integrating health and social care,' a role not explicitly included in the three core tasks of PCGs, but which implied a requirement to go beyond building *ad hoc* relationships between primary care and frontline social services staff, and to build strategic collaborative arrangements between health and social care organisations with a view to improving the delivery of both services.

It was understood at a senior level that the services were interdependent at an operational level.

> *Undoubtedly community nursing and social care is important - there are obvious overlaps between district nursing teams and some of the care management teams that go into older people's homes, and that's the territory we need to collectively get into. Things like the shared care protocols have helped clarify responsibilities and roles in the past, but actually there's a lot more that we could be doing there.* (PCT chief executive)

The representation of social services on the executive committee was not an effective mechanism by which to improve the organisation's capacity for collaboration. Instead, structural changes at the senior levels of both organisations which did promise to improve the capacity for collaboration, were initiated within the social services department and the appointment of a new chief executive.

A more optimistic outlook for primary care-social services collaboration was evident by early 2003, towards the end of the fieldwork period for the study. The social services department was renamed the Department of Social and Health Care, and chief executives of all five of the county's PCTs contributed to the process of selecting the new Director. The new title and the selection process suggested a new readiness to collaborate at a senior level. Although at first it was viewed with suspicion in some quarters, there was a sense of optimism that new leadership of the Department of Social and Health Care would present opportunities for better collaboration than that which had characterised the first three years of PCG/T - social services relationships. It was anticipated that closer strategic links between the two organisations, combined with the PCT's employment of community nurses, would increase the

capacity for general practice, community and social care to collaborate effectively.

> *"Some of my colleagues thought it was threatening to the NHS. 'Are social services planning to take over?' I saw it much more positively: this is signalling an intention to bring social services closer together.* (PCT chief executive)

> *"Organisations that were looking inwards, once there's someone new around, start to look outwards again and can be more confident. Once you've got new leadership there are a lot of positive things you can take forward.* (PCT chief executive)

The fieldwork period was over before the outcomes of these changes could be assessed.

Summary: This section explored the role of the SSD member on the governing bodies of the PCG and PCT and whether it allowed primary care to develop in ways which took into account the perspectives of both health and social care.

It argued that SSD representation on the PCG board was considered to be of very limited effectiveness. It depended heavily on individuals who were not always available. Establishing the PCG as an organisation, and its perceived medical domination impeded collaboration with social services. Geographical boundaries and different internal structures and financial pressures also presented challenges for collaboration. Collaboration between the PCT and SSD promised to be more strategic and with higher level oversight.

6.6 Summary

This chapter has presented findings in relation to RQ4 (set out in section 3.7) which asked whether Oxford City PCG's and PCT's organisational forms facilitated a collaborative approach to developing and delivering primary care services for their population. Primary care had previously been fragmented and unco-ordinated, dominated by GPs who were largely unmanaged and unregulated. The PCG's and PCT's budgetary and clinical governance responsibilities meant they had to rein in GPs' spending, control their clinical practice and encourage them to take a more corporate approach to their practice. This was likely to be challenging, given the medical profession's

history of fiercely-guarded autonomy. Four features of the PCG and PCT models, as set out in the analytical framework (section 3.6) potentially equipped them to meet this challenge.

This section returns to the fourth research question and draws conclusions about how it can be answered with reference to data from chapter six.

RQ4: How far did the following features of PCGs' and PCTs' organisational forms equip them to bring together primary care workers in the community to develop and deliver primary care?

- their locality-wide base
- the election of practising clinicians to their governing bodies
- their budgetary and clinical governance responsibilities
- the inclusion of a local authority social services department (SSD) representative on their governing bodies.

Locality-wide base

The PCG/T's locality-wide base allowed the PCG to perform consultative functions and to be a point of contact for other organisations who wished to collaborate with primary care on a city-wide basis.

PCG/Ts constituted an overarching primary care organisation which brought together GP practices and other primary care workers within one loose organisational structure with shared responsibility for budget and quality. The existence of a single overarching primary care organisation for Oxford City meant others had a point of contact for the local primary care community to which they could bring issues of local concern. Over time the PCG developed relationships with its constituent practices through consultations, meetings and visits, and increased its usefulness and credibility as its mouthpiece for the primary care community.

The PCG set up subgroups whose focus was the development and delivery of primary care in the locality of the city. The work of the Primary Care

Development Group, the Clinical Governance group and the Training and Education group was focussed on the policy, practice and organisation of the primary care community itself The training and education, newsletter and service development initiative brought together primary care clinicians and managers to deliver and develop primary care.

The PCG chair identified a need for a GP forum to bring together GPs in a similar way to the nurse forums which predated the PCG. Unlike nurses, there was no obligation for GPs to attend their forum meetings and they did so in small numbers other than when the topic directly affected their practice resources.

The existence of the city-wide organisation itself, and its subgroups and professional forums, all contributed incrementally to reducing general practices' isolation from one another.

The direct employment of community nurses by the PCT, on the other hand, had no discernable influence on the way they collaborated with one another or with other professional groups during the period of the fieldwork for this study. Contrary to some people's hopes, it did not result in an alignment of their professional or employment status with those of GPs.

Clinicians on governing bodies

The election of clinicians to the governing bodies of the PCG/T was more effective in the context of primary care delivery and development than in the context of health improvement. Clinicians adopted both strategic and representative roles. In the PCT a larger range of clinicians was included, but nurses were difficult to recruit. The influence of clinicians on PCT was perceived to have been diluted by the transition from PCG to the more bureaucratic and centrally-controlled PCT.

Dismantling GP fundholding was a challenge made more acceptable by input from clinicians, yet ex-GP fundholders felt stigmatised in the new democratic PCG environment, and that the hard-won service development and commissioning skills they had developed as fundholders were not exploited by the PCG as they should have been.

The long-standing status and power differentials between different professional groups, notably doctors and nurses were partially challenged by the composition of the governing bodies of the PCG and the PCT by giving

them almost equal formal status as board/PEC members. However, their actual status on these governing bodies was not quite equal: The longstanding status differentials of board members were deeply culturally and professionally embedded, and could not be redressed simply by changes to organisational structures.

The PCG model was welcomed by clinicians, but nurses' enthusiasm for it waned as it became clear that challenges to power differentials between them and GPs were only partial. As central control of PCG/Ts increased, the role of clinicians on their governing bodies reduced.

The PCT's separation of board from PEC meant that the professionals on the executive committee were, and felt, further removed from their colleagues in the primary care community. The transition to the bureaucratically more complex PCT exacerbated ambiguity of channels for clinicians to influence policy. Their peers expressed concern that the pure clinician identity of the executive committee had been compromised. This reduced trust and loyalty, and thus the networks, between the PCT and the doctors and nurses in the primary care community. The occupation of the PEC rather than the board did not in itself seem to marginalise clinicians' interests. The continuity of GPs from PCG board to PCT PEC provided one of the few threads of continuity between the two organisations.

The composition of the PEC became more inclusive and egalitarian than the PCG board had been. More primary care health professionals (pharmacist and a therapist were added) so as a collaborative mechanism it could reach a wider section of its clinical constituents.

Community nurses became employees of the PCT but these new employment arrangements had little effect on their professional status or their day-to-day work. Their inclusion in a larger, more powerful organisation paradoxically made them feel less influential in primary care policy, and this was reflected in the difficulty the PCT had in recruiting nurses to two new posts on the PEC.

Clinical governance and budget

Clinical governance and the development of primary care were taken seriously and prioritised by Oxford City PCG, and clinicians on the board were keen to be involved in the process. The involvement of primary care clinicians in all steps of the process was actively encouraged. Many of the PCG practitioner board members engendered their colleagues' trust in the processes, minimised resistance from GPs and supported their collaboration in developing and adhering to clinical governance policies.

A bottom-up approach was taken by the PCG board and clinical governance subgroup to designing strategic budgetary and prescribing policies. Clinicians themselves were involved in the process of identifying the priority areas for clinical governance. Practices' performance against targets (initially locally defined, but latterly identified by central government in the *NHS Plan*) was assessed and fed back using anonymised data. Training and education were provided by the PCG and PCT to support clinicians in the pursuit of good practice. The PCG's facilitative, non-coercive approach to clinical governance, led by clinicians, ensured that what was potentially a confrontational process was facilitated and negotiated, and did not present an unacceptably strong challenge to professional self-regulation. Its effectiveness was demonstrated in the successful reduction of prescribing spend in the city.

SSD representative on board

The SSD was represented on the governing bodies, which was designed to allow primary care to develop in ways which took into account the perspectives of both health and social care. The effectiveness of social services representation on Oxford City PCG board was difficult to discern and a sensitive area for discussion in interviews. At an operational level, a degree of everyday *ad hoc* collaboration between SSD care managers, community and hospital nurses and GPs predated the PCG. However, I found no evidence that the PCG furthered operational level collaboration between health and social care practitioners, or systematic, strategic collaboration between the PCG and social services. Structural and geographical differences between health and social care were longstanding barriers to collaboration, and neither SSD representation on the PCG board itself, nor the changes made to the seniority of the SSD board representative, overcame this. The SSD representative was

not directly accountable for her contribution to the PCG to anyone in the SSD nor in the PCG. The PCG did not use SSD representation to tap into the democratic function of the local authority. SSD found it difficult to respond to each of five Oxfordshire PCGs, and their longterm financial pressures left them ill-equipped to adapt to challenges.

Chapter seven: Nested case studies

7.1 Overview

This chapter is the third of three findings chapters which examine the PCG's and PCT's collaborative capacity and practice, the third element identified in the realist theoretical framework.

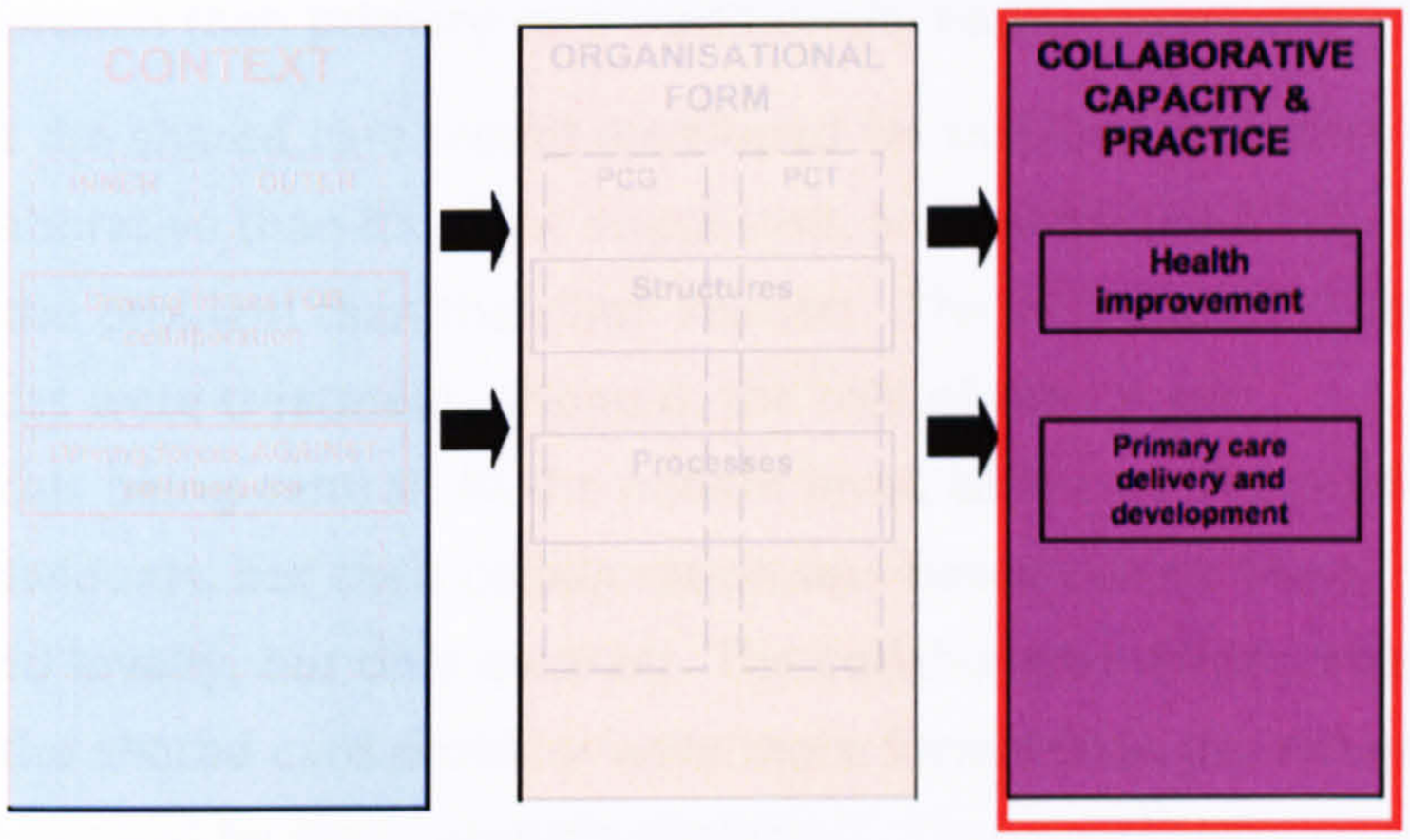

Figure 8: Realist theoretical framework - collaborative capacity

Two of the PCG's Health Improvement Programme (HImP) priorities were to tackle substance misuse and to promote independent living in older people. They were identified as key issues for health improvement by the range of NHS and non-NHS organisations who took part in the early consultation to agree the local HImP priorities for Oxford. This chapter addresses research question 5.

RQ5: Did the PCG's and PCT's collaborative capacity manifest in collaborative processes and outcomes at operational levels to tackle substance misuse and to promote independent living in older people?

It reports the findings of the nested case studies, which examined how Oxford City PCG and PCT engendered collaborative capacity and practice relating to these two HImP priorities. It is structured around the organisational features of the PCG and PCT identified in the analytical framework (figure 6): the PCG's explicit health improvement remit (in section 7.3); its locality-wide base (7.4); its clinical governance and budgetary responsibilities and the composition of its governing bodies (7.5).

Section 7.2 introduces the two nested case studies. It recaps the reasons for selecting the promotion of independent living in older people and tackling substance misuse as case studies: essentially that the needs of each group spanned a number of organisational and sectoral boundaries and the PCG/T appeared to be well positioned to facilitate collaboration between them.

Section 7.3 examines the influence of the two organisations' specific health improvement remit on their engagement with the complex problems exemplified by the nested case studies: did they adopt a more collaborative, upstream approach than primary care traditionally had?

It argues that the shared care model developed for tackling substance misuse was less collaborative than its name suggested, and presented a less upstream approach to the problem than the HImP implied. The PCG and PCTs' substance misuse services were treatment-oriented, the role of the GP and pharmaceuticals being central. At the patient level, each case required input from four individuals, but their collaboration was based not on trust, reciprocity and loyalty, but on a contract. The collaborative arrangements specified by the shared care protocol were more formal than the network relationships implied by New Labour's rhetoric.

Elements of the PCG's services to promote independence in older people, in contrast, took a distinctly upstream approach, developing non-medical, collaborative interventions designed to reduce hospital admissions and speed hospital discharge. The PCT claimed its relationship with the SSD (renamed the Department of Social and Health Care) would be more strategic than the PCG's had been but the intention to adopt a preventive approach to promoting independence in older people was retained. There was evidence that the increasingly centrally-driven target culture impeded upstream work to promote independence in older people.

Section 7.4 investigates the significance of the PCG's and PCT's locality-wide base for collaboration to address these two HImP priorities.

Understanding its significance for its efforts to tackle substance misuse requires an awareness of the history of drug service provision locally. The local context in which drugs services were to be developed was one in which specialist services were being withdrawn and a minority of doctors had taken on a disproportionate amount of work with drug users, at what was perceived

to be an unsustainable cost to their practice. Therefore, a key challenge for the PCG was to foster a sense of collective responsibility for addressing the city's substance misuse problems. The locality-wide base of the PCG was seen as key to redistributing the workload more fairly across the city.

This section argues that power differentials between GPs, managers and other clinicians, as well as GPs' professional autonomy, presented impediments to developing a collective will to provide services across the city. These impediments were largely overcome by the PCG's appointment of a 'specialist generalist'. Her identity as a former GP allowed her to operate as a boundary-spanner between the PCG and different professional groups, and helped to engender clear and robust collaborative working with drug users amongst previously reluctant GPs. This was effective in redistributing the treatment of drug users across a larger number of city practices.

A major challenge in the promotion of independence in older people was to tackle problems surrounding hospital discharge. This required that different professional groups improved their understanding of each others' roles and that appropriate discharge procedures and protocols were put in place. This chapter argues that the PCG's locality-wide base positioned it well to facilitate better understanding of roles and to improve referral procedures around hospital discharge across the geographical area.

Section 7.5 focuses on the impact of clinical governance, board composition and budgetary aspects of health improvement priorities on collaboration: three design factors which combined to reveal the vision of the PCG/T as corporate cultures that emphasised collective responsibility.

The rationale for the presence of clinicians on the PCG/T governing bodies was partly that this would engender a sense of cohesion and corporacy. It would bring a more strategic approach to improving the quality of primary care, and facilitate the sharing of good practice across professional groups and practices. Board clinicians would have credibility with their colleagues, and so would persuade them to implement PCG/T policy across the city practices. **This section argues that,** some GPs and a PCG/T manager felt passionately that the shared care of drug users was a valuable area of work, but this view was not represented on the PCG/T governing bodies. Although a substance misuse services development officer was appointed, and the board eventually

ratified proposals to introduce shared care for drug users, many of the board GPs were themselves hostile to the idea that heroin users should be treated in primary care so were not motivated to bring their GP colleagues with them in taking on this area of work. In this case, having clinicians on the governing body of the PCG was not effective in implementing 'official' PCG policy.

Individual doctors' resistance to working with drug users stemmed from issues related to levels of remuneration and fear of being overwhelmed by demand if "floodgates" were opened. The PCG/T's corporate reluctance to prioritise it derived from the fact that it were not centrally performance managed on substance misuse services, and the funding for it came not from their budget, but from the local Drug Action Team. The factor which was most effective in bringing GPs on board with shared care was the appointment of the 'specialist generalist.' Her identity as a former GP made her arguments were more persuasive to GPs than those of the PCG manager. She was also better able to influence the drugs workers.

The inclusion of clinicians on the governing bodies was designed to overcome the traditional animosity between managers and professionals which is said to arise from their different motivations: professional and altruist amongst clinicians, and hierarchical and careerist in managers.

However, **this section argues that** the managers and clinicians deviated significantly from their respective stereotypes. Managers did not always behave like "bean-counters." In the PCG, they were manifestly motivated by social justice and public-spiritedness. Controversy surrounding remuneration of GPs bore testament to the degree to which they were financially motivated. It also illustrated the contractual, rather than network-based, nature of collaborative working.

The inclusion of a local authority SSD representative on the PCG/T governing bodies was designed to facilitate closer working between primary care and social services on the planning and delivery of services. **This section argues that** the intermediate care services set up to reduce pressure on acute services by reducing the number of hospital admissions amongst older people and to facilitate effective and timely discharge from hospital did not arise as a result of SSD representation on the governing bodies of the PCG/T, but were rather brought about by new collaborative relationships at senior levels of SSD and PCT management, and were facilitated by the Health Act Flexibilities.

7.2 Introduction to the nested case studies

In chapter 4, I set out the argument for conducting two parallel longitudinal case studies of two of the HImP priorities: 1) tackling substance misuse, and 2) promoting independent living in older people. These HImP priorities were selected because the needs of both groups spanned a number of organisational and sectoral boundaries, yet they exemplified contrasting issues in terms of client group, aims and outcomes of the interventions, and illustrated collaboration between different sets of organisations.

Semi-structured interviews were conducted at two time points with PCG/T staff, local authority officers and managers, clinicians and some voluntary sector organisations. An interview schedule (see appendix 2) outlining the main topics to be covered was sent to participants in advance of the interview, tailored to the profession or position of the individual participant and the stage of iterative data analysis. Interviews focused on people's perceptions and experiences of the PCG/T's impact on collaborative activity in these two areas of work.

7.2.1 Substance Misuse

Substance misuse in many ways exemplifies a complex health and social problem. It has implications for health inequalities, criminal justice, housing, employment and social exclusion as well as medical morbidity and mortality.

> The management of drug misuse and dependence presents a considerable clinical challenge to all practitioners. However, delivering treatment well and gaining good outcomes, enhances clinicians' competence and confidence in tackling these complex problems, to the benefit of the individual patient and to society. (DH,1999)

Heroin was identified as the most problematic illicit drug at the time in the city. The prevalence of heroin misuse in Oxford was growing rapidly at a time when the specialist drugs services, which had previously taken referrals from GPs, had been cut back. Nationally, the profile of drugs service provision was

highlighted in 1998 by the launch of the Government's ten year drugs strategy *Tackling Drugs to Build a Better Britain* (Home Office, 1998), and In 1999 *Drug misuse and Dependence: Guidelines on Clinical Management* (DH, 1999) was published.

7.2.2 Care of older people

Older people were a group whose needs were often unmet, nationally and locally, because they fell through gaps between services. This was identified as a priority for the NHS and social services with the publication of the *National Service Framework for Older People* (DH, 2001b).

A major challenge for health and social services was to stop the 'revolving door' of hospital admission and discharge. Older people were frequently admitted and readmitted to hospital due to gaps in services in several places throughout their pathway of care. There were several possible sites of intervention, and the PCG/Ts' wide remits provided many opportunities to intervene. In particular, their health improvement remit could promote health and prevent hospital admissions. Their position as a locality-based primary care organisation suggested they could act at a locality level to improve communication and interaction between primary care, secondary care, social services and voluntary organisations, to help clarify their remits and co-ordinate their activities. In theory, their budgetary responsibilities allowed them to direct NHS funds where they were most needed and combine them with SSD funds where required. The inclusion of an SSD representative on the board/PEC was designed to facilitate a collaborative channel between the PCG and the SSD although, as chapter five demonstrated, this was not a very effective channel for change.

7.3 Health improvement remit

Section 7.3 examines the influence of the two organisations' specific health improvement remit on their engagement with the complex problems exemplified by the nested case studies: did they adopt a more collaborative, upstream approach than primary care traditionally had?

7.3.1 Substance misuse

Substance misuse was an issue which touched on the work of many bodies and agencies, including local authority departments and a range of voluntary sector organisations. It was identified as a HImP priority which, given the multi-agency nature of the HImP and the terms of reference of the PCG's HImP group, suggested an upstream approach might be adopted, with a greater emphasis on broad determinants of health than primary care had previously taken.

However, the PCG's and PCT's efforts to tackle the problem of substance misuse were to develop primary care based services for heroin users to which the GP role and pharmaceuticals were central. A 'shared care' treatment model based on prescribing methadone (an opiate substitute) was promoted. Underpinning the shared care scheme was a contract which specified the responsibilities of four parties: the drug user, a GP, a drugs worker and a pharmacist, and was signed by each party. This model had been adopted in other parts of the country, and a substantial evidence base demonstrated its efficacy in reducing mortality and morbidity in heroin users (Keen, 1999a). Methadone maintenance treatment had some vociferous proponents, who believed it should be routinely delivered within a well designed shared care system in primary care.

> When the effectiveness of a relatively inexpensive treatment such as methadone maintenance in reducing mortality and morbidity is now so well established, for how long can it be considered ethical for some general practitioners to refuse to prescribe it within a shared care framework? (Keen 1999a)

At first sight, this approach to tackling substance misuse bore little resemblance to collaboration embodied as a network mode of governance based on relationships of trust, reciprocity and loyalty. It took a treatment-oriented view of a problem which had strong social, economic and environmental influences. This shared care model focussed on treating individuals and was based on a formal contract between the four individuals, backed up by a system of financial remuneration. Nor did it obviously relate to the defining features of the PCG's health improvement remit which implied taking an upstream, broad view of the determinants of a population's health.

However, it was collaborative in the sense that the four-way agreement required three of the four parties from different professional and occupational groups to sign up to the scheme and to work together to pursue the health of the drug user. Also, the reduction of health inequalities and 'harm reduction' were underlying aims of the substance misuse services. The drugs worker's role was largely to address health and social concerns other than the user's addiction itself, such as health promotion, housing and benefits, and to provide a link with other organisations and agencies whose services were needed by the drug user. A strong public health ethos motivated the GPs who worked with drug users prior to the PCG's development of substance misuse services.

It also required a degree of corporacy in the primary care community jointly to take responsibility for a problem which seemed not to be acknowledged as a priority and had previously been regarded by GPs as a specialist area of treatment.

> *A change of heart is needed. A change of culture, philosophy, which is notoriously difficult to bring about historically, in the area of drugs. Without that change of culture the GPs of any big city will more often be treating the worried well more and more, and the genuinely needy will fall by the wayside once again. And that isn't the idea of care. The inverse care law is very well illustrated in Oxford.* (GP5)

7.3.2 Promotion of independent living in older people

The PCG and PCT's health improvement function (along with their budgetary responsibilities) implied a role in breaking the cycle of the overuse of acute services as a result of a lack of investment in low-level health promotion and preventive services (Rummery & Coleman, 2003).

One of the PCG's early health improving collaborative ventures was its involvement in the Small Repairs Scheme. It was a county-wide initiative developed by the PCG, SSD, Oxford City Council, Oxfordshire District Councils and Anchor Trust, a voluntary organisation, to enable older people to live in their own homes as independently as possible. It aimed to promote independence in older home owners over the age of 65, to help them to live as independently as possible, and to help prevent accidents in the home. It was aimed at older owner-occupiers and, in the early days, its 'handyman' carried

out small plumbing, joinery and electrical jobs and small adaptations around the home in return for a fixed fee. It came into effect in 2000 and the PCG's role in the scheme was to advise on the development of the service, to contribute towards the funding and to disseminate information about it to primary healthcare teams (PHCTs) and encourage them to refer patients to the scheme where necessary.

With input from the PCG, the scheme was developed further with a view to speeding discharge and preventing readmission, through collaborative working with other services. For example, training was given by occupational health and physiotherapy staff to enable the handyman to identify inconveniences, hazards and risks and to do home safety checks. He was trained to advise clients how to avoid trips and falls and was sometimes asked to prepare a home for someone about to be discharged from hospital.

The scheme exemplified a low-technology, non-medical intervention which, according to the evaluation presented to PH&I group May 2002, succeeded in preventing admission to hospital and speeding discharge by providing minor adaptations and aids within the home and bypassing long waiting times to access statutory services. Its two year review claimed to demonstrate its cost-effectiveness in terms of prevention when the cost of a hip fracture was considered, and that it allowed the fast-tracking of people in hospital to speed discharge and prevented readmission. In its second year, the number of people accessing the service increased by 10%, the proportion of black and minolty ethnic (BME) people accessing it increased by 6.5%.

It was a project in which the HImP Group took an ongoing interest. It was not nearly as high profile or financially prioritised as the major elements of the intermediate care strategy, but the PCG's involvement was ongoing over its first two years, largely because of the HImP team's involvement. The fieldwork ended before it was possible to know whether this input would be maintained by the PCT's restructured public health team.

Summary: This section examined the influence of the two organisations' specific health improvement remit on their engagement with the complex problems exemplified by the nested case studies.

It argued that the shared care model developed for tackling substance misuse was less collaborative than its name suggested, and presented a less upstream approach to the problem than the HImP implied. Elements of the PCG's

services to promote independence in older people, in contrast, took a distinctly upstream approach, developing non-medical, collaborative interventions designed to reduce hospital admissions and speed hospital discharge.

7.4 Locality-wide primary care organisation

This new model of primary care organisation provided a structure which aimed to lend cohesion to the primary care community in a locality, and to bring primary care together with other local health and social care organisations. As chapter three showed, this was a key change to the way primary care was organised. The PCG/T's provision of services to drugs users and older people sought to address poor collaborative working arrangements, to encourage developments in primary and community services and had a public health focus. This section investigates the significance of the PCG's and PCT's locality-wide base for collaboration to address these two HImP priorities.

7.4.1 Substance misuse

The PCG identified a need to provide accessible and high quality drugs services across the city and, as a city-wide organisation, seemed geographically well positioned to do this. The need for such services, and the challenges inherent in meeting this need, are best understood in the context of the national and local situation with respect to drugs services.

> *What's happening in Oxford is that secondary services tend to be under-resourced and overstretched and therefore the relationship between primary care and secondary care services is under tension and strained... There are areas where there is a good service and we're definitely one of the areas where there isn't.* (PCG substance misuse services development officer)

Drugs services in Oxford

A survey of city GPs was conducted in April 2000 to benchmark initial involvement with drug users, and in July 2000 a stakeholders consultation event was held to identify local needs and requirements. Their findings were summarised in a paper to the PCG board in July 2000 (00/17). 62 GPs responded to the survey, indicating that between them they had about 500

definite or possible class A drug users. Support, training and remuneration were cited as major elements which needed to be addressed if PHCTs were to feel able to take on shared care of drug users. GPs were aware of charges made against doctors for mis-prescribing methadone in other parts of the country, highlighting the importance of protocols.

In brief, prior to the PCG's introduction, services for drug users in the city had been provided by specialists in the psychiatry department of an acute hospital, but this service was no longer accepting referrals. The remaining services were inconsistent in quality and inadequate to meet the needs of Oxford's drug users. Oxfordshire Mental Healthcare Trust had a community-based team of psychiatric nurses, the Specialist Community Addiction Service (SCAS), who treated a caseload of drug users with some methadone maintenance, but their practice was not supported by the latest evidence base, and their service was 'silted up', i.e. the waiting list was too long to allow them to accept further referrals. Four general practices in the city provided some methadone maintenance treatment for heroin users but some of these GPs felt inadequately supported in this. One of these practices was a primary care service set up specifically to meet the needs of homeless people and staffed by salaried GPs, another was a practice whose patient list included bail hostel residents, and a third was a single-handed practitioner who had developed a reputation for treating drug users, and had on his patient list a disproportionate number from across the city. The fourth ran a regular practice in a deprived part of the city and treated a small number of drug users. Some other GPs provided general medical services to a small number of patients who were drug users, but provided no specific treatment for their substance misuse.

In other parts of the UK, the development of primary care-based substance misuse services had demonstrably improved access to evidence-based treatment from GPs who were trained and supported in this work. The PCG believed this model would benefit drug users in Oxford by ensuring access to high quality services, as well as normalising the treatment of drug use in the community and removing the stigma of attending a specialist clinic. From the point of view of the primary care community, it would distribute the workload more evenly across practices in the city and reduce the demands made of a small number of GPs who were bearing a disproportionate amount of this resource-intensive work.

Corporate approach to tackling the city's drugs problems

As section 3.2.1 argued, the PCG provided a locality-based body which could potentially foster a corporate culture and a sense of collective responsibility (Wilkin et al, 2001). Their introduction was an attempt to foster local ownership and control of locally defined needs, as well as a sense of shared identity and purpose in meeting them. In the context of developing substance misuse services, this meant the primary care community adopting shared ownership of problems relating to heroin use and a collective will to tackle them. If the proposed shared care scheme for the treatment of drug users was to be viable, the PCG had to recruit to it a proportion of their constituent GPs. That heroin use was a problem in Oxford was undisputed, but corporate ownership of the problem by GPs, and willingness to work together to tackle, it was difficult to foster.

One contextual factor which militated against the PCG's efforts to recruit GPs to the shared care scheme was GPs' autonomy and their independent contractor status. The PCG had no direct control over many aspects of their practice and, since substitute prescribing lay outside of the General Medical Services (GMS) contract, GPs had to be cajoled rather than coerced into taking part in the scheme. Resistance to signing up came in several forms.

Some objected to the principle of prescribing drugs for something they considered not to be an illness. Also, GPs were often aware of well-publicised cases where criminal proceedings had been brought against GPs when something had gone wrong, and this fear was sometimes reinforced by a section of the medical profession. Some Local Medical Committees (LMCs), for example, formally advised doctors not to prescribe methadone unless they were separately contracted to provide the service, warning against being 'blackmailed' into actions that could have 'severe legal consequences' and 'threaten their whole future careers' (Wessex LMC, 2000).

> *Methadone maintenance seems a very dodgy business. People die from it and doctors have been prosecuted. It's dangerous for me as well as for the patient. The aim is not to be taking drugs or medication, prescribed or street, unless there's some clear medical indication. That's a sort of philosophical thing that underlies all the doctors' prescribing here. Whether someone has a sore throat or a drug problem, we much prefer*

not to prescribe than to prescribe. It's much healthier and better, always, always, always. (PCG board GP1)

Colleagues' disapproval

Some GPs reported that their clinical partners were obstructive and disapproving of their work with drug users. They found this unacceptable in the light of the General Medical Council's (GMC) guidance that withholding treatment on the basis of moral judgements about a patient's activities or lifestyle would be unethical (GMC, 1999) and argued that it might even raise questions of serious professional misconduct. But, given this sometimes hostile GP culture and the high stakes involved in methadone prescribing, solid support, in terms of both multidisciplinary teamwork in primary care, and access to secondary services to which to refer complex cases, was perceived as absolutely crucial. This support was often absent, and recent upheaval within the Mental Healthcare Trust contributed to confusion:

We feel a bit beleaguered and quite isolated; as a practice we feel we haven't got any backup if we do take addicts on, and I personally feel it within the practice because I know my other partners really disapprove of it. The official policy is not to run methadone programs. (GP 3)

We have been asked to do written referrals to the specialist service via [name of Community Psychiatric Nurse] at the Community Drug Team. We get letters back saying 'we're sorry there's no service at present. There may be one in January.' Sometimes floating around are hints that there may be a locum consultant available, but we're not told about that. (GP 4)

I think the specialist services have completely collapsed now. (GP 1)

Drugs services developed

After very lengthy negotiations and ongoing work, to which the city PCG's Methadone Prescribers Group contributed significantly, shared care protocols were drawn up for the whole county and launched by the Oxfordshire Drug and Alcohol Action Team (DAAT) in June 2002. The shared care plan included:

- therapeutic intervention to promote change, provided by a GP Liaison Worker (GPLW) (eg motivational interviewing, cognitive behavioural therapy)

- pharmacotherapy if appropriate, prescribed by the GP or Intermediate practitioner and dispensed by arrangement at a named pharmacy
- social support provided by a voluntary agency, the probation service, school nurse, health visitor or other professional (Oxfordshire DAAT, 2002)

However, implementing the shared care model was managed by a non-clinical PCG manager. He faced considerable challenges in recruiting GPs to the scheme. This was a fraught task, which in many ways exemplified manager-professional tensions. It also required that he grapple with the differentials in power and status between GPs and other groups, which derived largely from their tradition of professional autonomy and independent contractor status. At times the animosity between clinicians and managers was evident in the slow progress made in bringing GPs on board. The manager was aware of this manager-professional divide, and took steps to find other doctors to instil credibility in the shared care model.

The recruitment of GPs to the scheme was eased partly by the employment of a specialist generalist, "intermediate practitioner". By 2002, the intermediate practitioner had become known as the Specialist GP in Addictions and her remit was broadened to the promotion and support of the shared care of drug users, to provide clinical care in shared care clinics, and to offer advice and support for GPs for individual cases, as well as facilitating the continuing education of GPs. Crucially, her remit included supervision of the SCAS nurses. A parallel post of Development Pharmacist addressed issues and facilitated training for pharmacists signed up to the scheme, as well as managing and developing needle exchange schemes across Oxfordshire. GP liaison workers provided assessment, care management and planning, detoxification, counselling advice and support. A Shared Care Monitoring Group addressed issues such as clinical governance and data collection, education and training, and would advise the DAAT treatment subgroup. Membership included representatives from the Local Medical Committee, Local Pharmaceutical Committee, PCTs, DAAT and the development pharmacist and specialist GP. A set of treatment guidelines were provided for GPs and community pharmacists, and Shared Care Lunches replaced the Methadone Prescribers Group, providing a forum for GPs, pharmacists and other shared care workers to discuss clinical issues, which were then fed to the Shared Care Monitoring Group.

As well as engendering trust in the process, the shared care protocol constituted the basis for clear and robust partnership arrangements. Within them, the role and expectations of each professional group was made explicit so each professional could be clear about their contribution to the overall care of the patient/client, and what they could expect by way of support from their colleagues. Within a framework which provided safeguards to protect confidentiality of clients, arrangements were formalised to share information. The role of the pharmacist, for example, was key. They were the professional who, if the patient was collecting their methadone daily, would expect to see the patient most frequently. They were therefore in an ideal position to inform the drugs worker or GP if the patient has not attended, which is then likely to imply reduced tolerance and danger of overdose.

7.4.2 Care of older people

As a locality-wide body, the PCG and PCT should be well placed to address problems across the city which occurred at the interfaces between primary care and social services and secondary care, and education about each other's roles. The PCT, as an organisation which also employed community nurses, would be expected to be in a stronger position still to foster collaboration between organisations and teams.

Hospital discharge processes seemed to be the source of many problems in the care pathways of older people. Insufficient hospital beds meant there was great pressure to discharge patients as soon as possible. Discharge procedures were, therefore, often a rushed reaction to this pressure, where the goal was to free up a bed rather than a timely and planned process in which the common goal was to protect the patient's best interests. Referrals were often made inappropriately, too late or not at all.

A lack of understanding of other groups' roles and sometimes even of their existence often impeded effective collaboration. This section examines these problems and the PCG and PCT's responses to them, as locality-based primary care organisations.

Hospital discharge

Hospital discharge was a key point in the care pathway of older people, and one at which collaboration often failed. Hospital and community health and social care staff all played roles which had to be co-ordinated at the point of

discharge, but the different organisational contexts within which each group operated meant their goals and interests were not always aligned.

Pressure to free hospital beds

Hospital staff reacted to acute pressure to free up hospital beds and to arrange discharge as soon as the patients occupying them were considered medically fit to leave. The term 'scattergun referral' was used to describe an approach to discharge planning whereby hospital staff made blanket referrals to anyone who might be able to facilitate the soonest possible discharge.

Many participants, including an outreach occupational therapist (OT), three district nurses (DNs) and a member of social services staff, felt the need to free up hospital beds overrode hospital staff's concerns about the patient's safety, long term recovery and the provision of the most appropriate care and treatment.

> When there's a crisis people just scream for help, don't they, although it may not be the right person. [outreach occupational therapist)
>
> *They tend to do a scatter gun approach - they ring all of us and say we need a bed at the community hospital, we need a bed at the RI for rehab, we need a care package, and so on. That's how they go on, and not really clear what's the best thing for the client because they just try to make sure they go somewhere.* [social services hospital unit manager)

A district nurse's account of one older person's discharge from hospital illustrated many of the problems documented in the Audit Commission's report (1998a). A patient who had a social services care package and whose diabetes had been managed by the DN team for over four years was admitted to hospital. While in hospital, his diabetes treatment was changed and his care package at home was discontinued, so hospital and community nurses agreed that he would be discharged from hospital to a residential home. However, one day the district nurses received a call from the Care Manager to say he was coming home that day. The hospital had not contacted them to let them know his diabetes treatment had been changed, despite their vital role in managing it.

> *I spoke to them the week before and they were in agreement that he shouldn't go home alone, and then that's exactly what they did. So it was inappropriate discharging without the correct package of care to follow up, and then that lands on our doorstep, because once they're out in the*

> *community, the hospital can say 'They've gone, they're nothing to do with us.' And no matter what mess they come home in, one of us will have to go in the next day and pick up the pieces and sort out what happens to them from there on.* (district nurse 3)

Although they visited him the following day, he was readmitted to hospital within a matter of days. The district nurse understood his rushed discharge was the result of the hospital being under enormous pressure to free up beds, but argued that it was a false economy as poor discharge procedures often resulted in readmission.

Community nurses were sympathetic to hospital nurses and understood the pressures under which hospital staff operated, many having previously worked in a hospital environment.

> *I was the same when I worked in a hospital. Everything's done in the interests of earliest possible discharge. You think, 'They're sort of OK. Discharge them and let someone else deal with them'* (district nurse 4)

This incident was evidently not an isolated one. Interviews repeatedly reflected a context driven by an almost desperate scramble to free up hospital beds which sometimes took priority over patient safety as well as over the long-term interests of the hospital. Community-based health professionals all described instances of short-sighted and hasty hospital discharge. Without the right care and support at home for a patient, discharge was frequently followed by readmission to hospital, with the attendant disorientation and trauma for the patient, and wasted resources and time for the hospital.

This was a clear example of recurrent collaborative failure, driven by a context in which pressures of resources led to misaligned goals and interests.

Lack of communication and understanding of other groups' roles

The 'scattergun' approach to referrals reflected a desire to free up hospital beds as quickly as possible, but also a lack of effective communication and understanding of the roles of other professional and occupational groups. This pointed to a potential role for the PCG/T in improving awareness and understanding in other organisations, and input to protocols for appropriate referrals.

Information sharing around hospital discharge was reported to be inconsistent, unreliable and untimely. The amount, quality and timeliness of communication

between disciplines and professionals in hospital and in the community was variable and a source of frustration and inconvenience expressed by community staff in particular. Several district nurses complained that the primary healthcare team was not routinely informed of a patient's discharge from hospital, sometimes even when there was a clear nursing need, and certainly the information was not always received in good time. Most agreed that it would be helpful if they were informed in advance of a patient's discharge, even in the absence of an obvious nursing need, just so they were alerted to potential problems.

Community nurses and therapists reported that hospital staff frequently misunderstood how community staff work; for example, they might ask a district nurse to check the dressings of a mobile patient who would in fact be expected to come into the practice and be seen by a practice nurse. They commented on the effects of the high proportion of bank nurses and high staff turnover on hospital staff's grasp of what professionals in the community have to offer.

This district nurse reflected many others' experiences of misguided requests from hospital staff, and a tendency to stereotype them.

> *I think there's still a lot of hospital nurses that think district nurses just go round bathing people and doing a few leg ulcers. They don't actually realise the complexities of some of the cases that we will take on. So that leads to inappropriate referrals because they don't actually recognise our true goal, and sort of qualities in care that we can give. They think you're a lesser nurse, actually - you get that distinct impression sometimes. You're only in the district 'cause you couldn't make it in the hospital sort of thing, rather than the fact that you've actually chosen to come in to the community, do an extra degree or certificate and you know, you are quite a good nurse really, and you're quite capable of taking on other things.* (district nurse 3)

Others described difficulties in persuading staff on hospital wards to make referrals to them at all. Two voluntary sector organisations, Age Concern and the Carers Centre, were keen for their services to be used by those who could benefit from them. Both had made efforts to promote the potential roles of their staff and volunteers when patients were discharged from hospital, but take up of these services had been disappointing. The Carers' Centre reported

that while they had achieved some level of success in raising the profile of their services in general, securing appropriate referrals from the acute hospital was a particular and ongoing challenge. A social services unit manager also reported a large number of inappropriate referrals from the hospital. All three participants attributed this to the large number of bank nurses and high staff turnover, which meant they did not learn what services were available and how they fit together. Social services employed a discharge planning co-ordinator to inform nurses about how to make appropriate referrals, but this appeared not to have solved the problem.

> *Simple, unskilled things could be done by volunteers. It would require a cultural shift for statutory organisations to think laterally and involve voluntary organisations. We've tried giving project leader talks to GP practices. They're enthusiastic, but we wait for referrals and they don't come. (Director of Age Concern, Oxfordshire)*
>
> *What they've absorbed is that information about the Carers' Centre is part of discharge procedure. What we want it to be is part of the admission procedure because to do the most good we need to know about it the day they turn up to set these things in line for when they are discharged.* (Carers' Centre Manager)
>
> *We do get a huge amount of inappropriate referrals as people don't understand what we do. There's a lot of bank nurses, there's a lot of turnover of staff, which means people are not long term members of staff, they don't know about the services. They don't know what the red cross scheme provides, they don't know what the intensive support schemes provide, they don't know what we provide, they don't know how it all fits together. We looked at it once before about how to inform nursing staff particularly to enable them to make the appropriate referrals. Not just to us but to other disciplines - OT, physio and the various schemes really.* (social services hospital unit manager)

As a locality based primary care organisation, the PCG and PCT could play a role in improving communication and awareness of services. But the problems were more systemic. As its commissioning role developed, it could also intervene at a more strategic level to address the staffing and retention problems which led to the high number of bank staff. No evidence of influence

over secondary care through commissioning was evident by the end of the fieldwork period.

Lack of understanding of patients' needs on their return home

Other referral problems resulted from a lack of understanding of the problems faced by patients when they left hospital. One nurse described her experiences of the gaps in discharge planning and another described her problematic attempts at communication with ward nurses.

> *Time and time again there is a lack of understanding of how people will cope at home. They [hospital staff] are too optimistic, and inevitably you have a crisis on your hands.* (district nurse 2)

> *People don't know what we need. We chase them and leave messages for them and just hope one gets written down.* (health visitor 1)

Accounts of the levels of communication between different agencies were not always consistent. A hospital care manager, for example, felt that they did make every effort to communicate with their community-based colleagues and that their efforts were not reciprocated.

> *We try really hard. We leave messages on the district nurses' phone. Where's the two-way communication?* (social services hospital unit manager)

Referrals: community

Hospital discharge was not the only point at which referral processes were not effective. Patterns of referral between community practitioners to particular services were not uniform across the city. A domiciliary physiotherapist described differences in referrals between practices, between GPs within practices and their inconsistency over time.

> *I think if you were to peg out the pattern of referrals from one surgery to another, it'd be quite interesting. Certain surgeries, certain GPs within surgeries even, refer, and somebody else doesn't. Or you'll see a pattern where a GP will refer several people all of a sudden, and then it'll go very quiet, and it's as if something has reminded them that there is a service and they see a few people and they refer everybody. Then that tails off again. Or you'll end up writing them a letter about something, and this letter with this heading appears, and they think 'Ah,*

I went to see Mrs so-and-so yesterday, perhaps I could refer her there,' and that starts that cycle off again.. (Domiciliary physiotherapist)

The outreach occupational therapist (OT) service which relied on referrals, had actively worked at developing links with colleagues, other OTs in particular, to ensure good quality referrals. One of their staff explained that, since they had been established for less than two years, some inappropriate referrals were to be expected.

The outreach OT service and the domiciliary physiotherapist reported both inappropriate referrals and their concern that people also get missed. Frustration resulted from situations in which the waiting time for a referral to OT or physiotherapist was as much as two months, and once they arrived sometimes the problem would turn out to be a medical one and one which they were unable to help with.

Summary: This section investigated the significance of the PCG's and PCT's locality-wide base for collaboration to address the two HImP priorities. It argued that power differentials between GPs, managers and other clinicians, as well as GPs' professional autonomy, presented impediments to developing a collective will to provide services across the city. These impediments were largely overcome by the PCG's appointment of a 'specialist generalist'. The PCG's locality-wide base positioned it well to facilitate better understanding of roles and to improve referral procedures around hospital discharge across the geographical area.

7.5 Clinical governance, board composition and budgetary arrangements

. In this section I take together three key themes which implied potential as mechanisms to facilitate collaboration within the primary care community to develop and deliver services: clinical governance, board composition and budgetary arrangements. These were experienced as a complex and interwoven network of influence which to some extent went towards revealing the nature of the "vision" behind the PCG/T: a corporate culture that emphasised collective responsibility (Wilkin et al, 2001).

7.5.1 Substance misuse

Tackling substance misuse was endorsed as a local HImP priority, yet it rarely featured on the agenda of the board meetings, and received relatively little support or interest from the board. When a proposal for the development of substance misuse services in primary care was eventually brought to the PCG board in July 2002, its response was defensive, emphasising the pressure that primary care was under. The board formally accepted the proposals but, crucially, only on the condition that extra work would not be incurred by GPs.

Insofar as this approach was predominantly medical and individually oriented, it might have been expected to be understood by, and to appeal to GPs. However, the board/PEC GPs themselves were not prepared to enter into the shared care scheme or to 'champion' it. In this case, the inclusion of clinicians on the governing bodies of PCGs and PCTs was not an effective means to lend credibility to PCG policy or to facilitate its rolling out across the primary care community.

Budgetary and clinical governance responsibilities

Many GPs saw the costs of accepting heroin users onto their lists as unacceptable. As independent contractors, the majority of GPs were paid a *per capita* fee of £17 per year for each young adult on their list, the basic capitation figure based on the assumption that most young people see their GP approximately three times per year. One aspect of the development of substance misuse services was to make the costs (financial and other) to GPs more tolerable by providing drug worker support and remuneration. At the time of the GP interviews, the remuneration level being mooted by the PCG was £100 per drug user per year. This was seen as inadequate to outweigh the financial disincentives to take on patients who were likely to make weekly appointments rather than the three appointments per year on which the per capita payment was estimated.

> *What it'll take to persuade GPs to look after these people is massive support, massive financial incentives and I'm not convinced that either of them are there in big enough quantities to really change the culture.* (GP5)

GPs reported feeling acutely overworked and lacking capacity to carry out additional work. Several GPs expressed forcefully a sense that they were being asked to take on more and more, but that this was not reflected in their pay.

The fear was also voiced that acquiring a reputation as a practice sympathetic to drug users would somehow open 'floodgates' and lead to being 'swamped'.

> *In relation to drug addicts, it feels like there's a floodgate. We see the statistics on the news all the time and we know that it's true because we come across the 13-year-olds in [area of Oxford] who are using. There's a sense that the floodgates will open and we're already feeling fairly overworked and overwhelmed in my practice... So adding drug addicts, who are very demanding, or perceived as that, is not something anyone's voluntarily going to take on.* (GP3)

> *Getting GPs to [treat drug users] is obviously hard work, but I think in principle any GP could do it. It's not complicated or difficult. It's emotionally very draining; the psychological drain of the work is such that I can really see why most GPs wouldn't want to get involved.* (GP5)

Virtually all the GPs interviewed commented on money-related issues, including one GP who worked very little with drug users who illustrated the significance of the financial disincentives, and another who had a disproportionately high number of drug users on his list and who emphasised the financial unviability of his work:

> *If we ended up having fifty drug users that would increase my workload by 30%. You just can't do that. And of course it's for no remuneration at all really. I know you get a yearly amount but that covers three consultations. The figure they were suggesting, £100 per patient per year, is better than nothing, but I don't think it still matches the sort of workload we're talking about.* (GP4)

> *Some people have no idea of the energy or time you need to expend where you could be earning other money. You have to expend time which makes you a vast loss on the accounts... But if you see a methadone user forty plus times per year, often for long appointments, one can understand that the funding basis has to be completely reviewed for this category of patients...If you assume 12 hours' face-to-face contact with a patient per year, plus a further five hours on related matters such as liaising with probation officers, social workers, writing letters to court etc, this would be £850. In many ways this is on the low side given the huge impact on the surgery that every heroin addict makes... If you believe people are worth looking after you do it, but*

> *essentially it's something you do outside the NHS and totally unfunded. If you do there are enormous ramifications of unfunded work because of time, energy and financial implications to the practice and personally.* (GP5)

On another occasion, GP3 suggested that such a payment would constitute a very baseline remuneration which would make treating drug users as lucrative as *"treating sore throats in a leafy suburb as a newly qualified locum."* This view was endorsed by the intermediate practitioner who reported that, in her previous post, the clinical assistant rate she had been paid for running methadone clinics was roughly this amount. Variations in the estimated costs are a function of a combination of factors, and arise partly from differences in the level of GP input. However, it was conceded that prescribing for drug users was time consuming, stressful at times, required a particular expertise and clinical commitment and was, for these reasons, costly. £100 seemed, to GPs and PCG staff alike, to represent a token recognition of this rather than a reflection of the true cost.

Funding for these services came from Oxfordshire Drug Action Team which combined representatives from local authorities (education, social services, housing) health, probation, the prison service and the voluntary sector. It worked across the county and had a pooled budget to spend on drugs services across the board, including prevention, treatment and reducing supply. The funding of the services, then, was not from the PCG which may explain why a corporate approach to the problem was not forthcoming. It was not a budgetary concern to the board, or a matter of clinical governance, so their incentives to tackle the problem were small.

Given that a major factor limiting the remuneration of GPs was the overall resource allocation, and that, arguably, treatment could be justified by its evidence-base in a way that 'limiting availability' could not, it was argued that such resource allocation incurred an opportunity cost. However, there was no evidence that the PCG attempted to exert influence 'upwards' on central government policy (which dictated that half of all drugs spending over the following four years would be on 'reducing availability'). According to a participant on the UK Harm Reduction Agency (UKHRA) discussion list (anon 2001), "DATs like that in Cleaveland have started to show that this can be a two-way process and that government policy can be questioned when it does not accord with local needs."

Local ambassadors

Commitment to and ownership of the work was initially polarised. Some GPs were forcefully opposed to doing the work, and others were passionately committed to it. The latter were good ambassadors for the rewards of working with drug users.

> *We've had people who were desperate, near death, on benzos and heroin and alcohol, and crime and every nasty illness that's possible, abscesses. Really ill people who've done amazingly well, come off not only heroin but also alcohol and the benzos. You can see them become alive again. When they get back into work, meet someone, have a child, and their life begins to work it's nice to see.* (GP5)

> *There are a lot of medical issues that confront substance misusers and in order to get the whole thing sorted and for them not to fall inbetween various stools and various specialists, I think GPs are perfectly placed. We've certainly found that here.* (GP6)

> *I think it's a very very good idea for a few different reasons. For one it makes it less stigmatising. It's much easier for a drug user to admit to a problem in the privacy of a GP surgery rather than having a separate agency. It means that the GP can deal with the whole problem holistically; they're not just looking at the drug problem in isolation, they're looking at the emotional problem that caused it in the first place. The third thing is they can pick up on all the preventive health work that you need to do with drug users like hepatitis immunisation and looking at injection sites, advice on safe injecting. That can be done at the drugs team. Sexual health, particularly among women is a big thing ... and a drugs agency which is just looking at the drugs wouldn't look at that.* (GP7)

> *I think in principle prescribing methadone in primary care is a good thing. My view on it has changed, having worked here and seen it in action. I think it's a relatively simple replacement therapy for a chronic disorder and should be viewed as such. It's purely the context in which you prescribe it that makes it so difficult in terms of the kind of patient, what's got them into that situation in the first place, their own troubles and problems, the legal issues, the fact that it's a high risk group*

anyway for dying, basically. Where you've got young people dying it's a frightening area. (GP6)

The limitations of methadone maintenance treatment were documented and acknowledged. Clearly, substitute prescribing in general practice is not a panacea for drug misuse generally. It is not a suitable treatment for all heroin users, and the importance of specialist psychiatric, medical or voluntary expertise in the treatment of patients with physical or psychiatric co-morbidity, or with other complex needs is undisputed (Gerada, Barrett, Betteron & Tighe, 2000).

Training day

Another effort to encourage GPs to work with drug users was to set up a training day, run jointly between Oxford City PCG and a neighbouring PCG. All primary care team members were invited, and a GP (and a keen proponent of methadone maintenance treament) from a primary care-based drugs clinic in Sheffield spoke. She was an effective ambassador for the scheme, and had credibility with her GP peers and other clinicians. She outlined the evidence base for methadone maintenance and described her overwhelmingly positive clinical and professional experiences of working with drug users using substitute prescribing in a shared care setting. The event was very popular, indeed oversubscribed, yet the extent to which this sort of event could be expected to reach PHCT members without a particular interest in the field, or positively resistant to it, was met with a small element of scepticism:

> *The event was very useful, but maybe some people would say 'You've got someone who's an advocate for methadone there. If you'd got somebody from another treatment philosophy then perhaps we'd have had just as convincing an afternoon with somebody saying, "Don't bother with methadone, use an abstinence approach and wheel in the therapy." But I think the evidence is that the usefulness of methadone maintenance has clearly been demonstrated.* (PCG substance misuse services development officer)

On balance, however, it was considered to have been more than an exercise in preaching to the converted. Feedback suggested a number or 'waverers' were convinced of the benefits of the treatment, enhancing the GP community's commitment to and ownership of the shared care model.

Intermediate practitioner

A 'specialist generalist' or 'intermediate practitioner' was appointed to support GPs in their work with drug users and to take referrals of complex cases.

Although it is difficult to be certain of the causal mechanisms at work, significant, if reluctant, changes in GPs' practice and in the the Specialist Community Addiction Service's (SCAS) treatment philosophy took place over the course of the study. The number of GPs signed up to the shared care scheme reached 54 by early 2003, and the SCAS team shifted from their non-evidence based treatment position to taking a more favourable view of it. These changes were due at least in part to three elements: the specialist generalist, the shared care lunches and national guidance.

Mistral and Velleman (2001) note the paucity of teaching at medical school on the subject of substance misuse. Given that a contributing factor to many GPs' reluctance to work with drug users was their lack of confidence in so doing, a further way to engender ownership of and commitment to shared care work with drug users was to enhance their skills in the area and, thus, their confidence.

The 'intermediate practitioner' played a key role in this respect. She had trained originally as a GP but had developed a special interest and experience in treating drug users and could act as an expert resource for GPs. She was employed by the MHT and jointly funded by the city PCG and another PCG, and her role was to work with primary care teams in the city, providing training, supervision and support to PHCTs, and to bridge the gap between primary and secondary care. The effectiveness and accessibility of the training and support she could offer to PHCTs was probably enhanced by her GP background.

The Specialist Generalist made a significant contribution here, playing a 'bridging' role where trust had been difficult to nurture. By virtue of her professional status, her experience of working in a shared care setting along with her personal characteristics of assertiveness and confidence, she was well placed and well equipped to build bridges between the primary care community and the specialist drugs team and to influence the drugs workers' practice. As non-clinicians, the PCG managers found it difficult to tell clinicians how they should practice.

Tensions between organisational groups

Between GPs and drugs workers, who were mostly psychiatric nurses, some lack of clarity about treatment aims and philosophy led to misunderstandings, but this was not primarily an issue of trust. Tensions were particularly high between the two organisations, the PCG and SCAS. The relationship between the development officer whose role it was to negotiate on behalf of the PCG, and his opposite number in SCAS was fractious.

> *I find it [SCAS] very difficult to work with. Even [senior clinician] I find disappointing to work with, and I think they feel similarly about me. The mutual sense of uncertainness of what's going to come out of any partnership work... It's very difficult to get any sense of what they're doing. They don't have Service Level Agreements, they don't have monitoring that I'm able to get hold of, they don't release any information. I'll be trying to bring in monitoring and I just don't know how that's going to be received.* (PCG substance misuse services development officer)

Despite lengthy negotiations about how, and how many, drugs workers would be deployed to support GPs in Oxford City, agreement was elusive. Further, while consistency of approach and philosophy between the professionals responsible for the shared care of a patient is essential, the treatment model (based on substitute prescribing where appropriate, in line with the national guidelines) as advocated by the PCG, ran counter to the more abstinence-based treatment philosophy of the SCAS team.

This had knock-on consequences at practitioner level, as was illustrated by anecdotes from GPs. One, having attended the training event at which the effectiveness of methadone maintenance had been forcefully driven home, was surprised to learn that her intention to follow this treatment model with one of her own patients, and with the support of a SCAS drugs worker, was met with a distinct lack of enthusiasm by one of the SCAS team. Another recalled occasions when he'd received phone calls from the consultant at the specialist team to "tell him off" for inappropriate prescribing, although he claimed it had been in line with the current evidence base and guidelines.

Interestingly, despite PCTs being technically the commissioners of the SCAS services, their influence on their practice was imperceptible. Admittedly,

Oxford City PCG's /T's leverage was arguably diluted as this commissioning role was taken on by one of the other PCG/Ts on behalf of the county.

The PCG took on responsibility for (co-ordinating) the city's Methadone Prescribers Group, whose meetings later became known as 'shared care lunches'. It was attended by a range of professionals including GPs, drugs workers, pharmacists who met at 6-weekly intervals to share experiences, support and information about working with drug users. They provided a useful forum for practitioners to increase their understanding of each other's roles and perspectives which, in turn, fostered inter-professional trust. Sometimes a speaker was invited for a more formal session, which constituted low-key multi-disciplinary training. These meetings almost certainly contributed to the convergence in the treatment philosophies of SCAS workers and PHCT members.

Professional, vocational approach vs managerialism

One source of animosity between managers and professionals is said to be their different motivations: the stereotypical professional is motivated by altruism and an ethical commitment to their expertise while managers are conformist, career motivated and self-interested (see 2.5.4). Indeed, the GPs who actively worked with drug users spoke frequently of a significant ethical and moral dimension related to the principle of tackling inequalities in health and significantly improving the health, in the broadest sense, of some of the most socially excluded members of society.

> *It's to do with the intrinsic value of the users, and to do with living in that reality rather than thinking that middle class undergraduates are more worthy of our time and energy than junkies are. There is a quality, a value there, and to refuse them is to live on a value scale that says they're less valuable. It makes me upset when I look at other GPs refusing them because they're actually making a value judgement about a human being which I think is invalid...If a similar number were dying of AIDS in Oxford every year, or breast cancer, there would be a huge outcry. Everyone would be wearing ribbons.* (GP5)

> *I don't agree with GPs who might say "we're not treating them because it's self-inflicted," because ultimately most heroin use is a band-aid on a huge emotional wound inflicted by another person, often a parent or a*

carer when they're in care, often sexual abuse. The root cause of heroin addiction is almost never self-inflicted. (GP6)

However, the majority of GPs in Oxford, apparently not sharing this conviction, chose not to work with drug users. The manager who developed the services, however, was motivated by the similar concerns about reducing inequalities in health.

There's a bunch of people there who, just because they're not polite middle class people like most GPs are it's a bit scary for GPs to work with them... But just because that person's being driven by something that doesn't make them say please and thank you and make them behave in the sort of way that I'm maybe used to, with the social niceties, should not exclude them from getting good healthcare. They fall foul of the inverse care law too often, when they're exactly where services are most needed. (PCG substance misuse services development officer)

7.5.2 Care of older people

The PCG worked with the SSD to develop specific services, in particular Community Rehabilitation Services (CRS) and Intensive Community Support Services (ICSS). The SSD representative on the PCG/T board and PEC was not influential in the development of these services, but they are reported nonetheless because they demonstrate collaboration between the two organisations which were important in addressing the issues of referral and discharge above. They were not developed exclusively for older people, but tended to be used predominantly by them. They were originally introduced as elements of a somewhat fragmented Intermediate Care Strategy to reduce pressures on acute services.

Community Rehabilitation Service (CRS)

The Community Rehabilitation Service (CRS) was developed locally and funded through the Social Services Partnership Grant, set up to fund psychological, social and environmental rehabilitation. It comprised a physiotherapist, an occupational therapist (OT) and a care manager working explicitly as a team with a single point of access, whereas previously they had been organisationally separate.

The line manager of physiotherapists in the city described a clear vision of the team, and expressed commitment to investing in team-building before it was on the ground. She placed great importance on that the team:

> *talking the same language and not caring who's paid by health and who's paid by social services* (CRS physiotherapist)

Team members would have their own skills but also shared skills, and would, in theory, serve the patient or client rather than their employing organisation.

Intensive Community Support Service (ICSS)

The ICSS team, run jointly by the Health Authority and social services department, was set up initially in 2000 as a pilot project. It provided services to prevent hospital admission and promoted early discharge from hospital, getting people back into their homes with extra care and support, again with an emphasis on easing the pressure on hospital beds and waiting lists. As such they were an integral part of the PCG's wider proposals for developing intermediate care across Oxford City (Primary and Community Services Update paper 24/01). Each team comprised a liaison nurse, an OT and a care manager/care co-ordinator. Demand for physiotherapy was not great enough to employ one as part of the team, but physiotherapy services were spot-purchased where needed.

In July 2001, twenty staff from Oxfordshire social services department transferred under TUPE (Transfer of Undertakings and Protection of Employment) to Oxford City PCT. These social care staff joined the wider PCT ICSS team using Health Act flexibilities, which enabled health and local government organisations to pool budgets for services. It became a permanent part of the local health community when a partnership agreement between social services and Oxford City PCT was signed in October 2001 (Primary and Community Services Update paper 24/01). In addition to Oxford City staff, other social care staff transferred to other Oxfordshire PCTs. Oxford City PCT held a "Partnership Agreement" with Oxfordshire County Council social services department on behalf of all Oxfordshire PCTs, to transfer money for the services from social services and to ensure delivery of agreed outcomes via joint monitoring arrangements.

This team took steps to avoid the lack of communication which was identified as problematic at hospital discharge. Communication between the ICSS team and other relevant players was taken very seriously:

On our assessment form we have 'Who have you notified?' - a list of about six, and there's a box for 'other', so you can put down who you've talked to and record if you've discussed something. We do really need to talk to an awful lot of different people: the family, the GP, the nurses, the referring care manager, the new care manager, all sorts of people - if they've got care management that is. We communicate extremely well. They might not agree but I think we do. (ICSS liaison nurse)

Summary: This section focused on the impact of clinical governance, board composition and budgetary aspects of health improvement priorities on collaboration. It argued that having clinicians on the governing body of the PCG was not effective in implementing 'official' PCG policy. The identity of the 'specialist generalist' as a former GP meant her arguments were more persuasive to GPs than those of the PCG manager.

This section argued that the intermediate care services set up to reduce pressure on acute services by reducing the number of hospital admissions amongst older people and to facilitate effective and timely discharge from hospital did not arise as a result of SSD representation on the governing bodies of the PCG/T, but were rather brought about by new collaborative relationships at senior levels of SSD and PCT management, and were facilitated by the Health Act Flexibilities.

7.6 Summary

This section returns to the fifth research question set out in section 3.7 and draws conclusions about how it can be answered in the light of data from chapter seven.

RQ5: Did the PCG's and PCT's collaborative capacity manifest in collaborative processes and outcomes at operational levels to tackle substance misuse and to promote independent living in older people?

It argued that the shared care model developed for tackling substance misuse was less collaborative than its name suggested, and presented a less upstream approach to the problem than the HImP implied. The PCG and PCTs' substance misuse services were treatment-oriented, the role of the GP and pharmaceuticals being central. At the patient level, each case required input

from four individuals, but their collaboration was based not on trust, reciprocity and loyalty, but on a contract. The collaborative arrangements specified by the shared care protocol were more formal than the network relationships implied by New Labour's rhetoric.

Elements of the PCG's services to promote independence in older people, in contrast, took a distinctly upstream approach, developing non-medical, collaborative interventions designed to reduce hospital admissions and speed hospital discharge. The PCT claimed its relationship with the SSD (renamed the Department of Social and Health Care) would be more strategic than the PCG's had been but the intention to adopt a preventive approach to promoting independence in older people was retained. There was evidence that the increasingly centrally-driven target culture impeded upstream work to promote independence in older people.

It argued that the history of drug service provision locally and national policy was key to understanding the significance of the PCG/T's locality-wide base to its efforts to tackle substance misuse. Prior to the PCG, service provision had been patchy and secondary care services were being withdrawn. The GPs who worked with drug users felt isolated and unsupported, and fears of 'floodgates' opening discouraged other GPs from working with drug users. A key challenge for the PCG was to redistribute the workload more fairly. PCG managers hoped that, to this end, the locality-wide base of the PCG would help to foster a sense of collective responsibility for the problem.GPs' autonomy impeded efforts to redistribute the workload in a context of low support and disapproval from colleagues. Once support was established in the form of a shared care model, power differentials between GPs and the others in the shared care team, and between GPs and the PCG/T manager responsible for implementing the scheme, presented further impediments.

These impediments were overcome, largely by the appointment of an "intermediate practitioner," a former GP who acted as a boundary-spanner between GPs and the PCG and the support workers. With this support in place, the shared care protocol engendered clear and robust collaborative working with drug users which was effective but more formal than relationships implied in the Third Way's rhetoric of networks.

A major challenge in the promotion of independence in older people was to tackle problems surrounding hospital discharge. This required that different professional groups improved their understanding of each others' roles and

that appropriate discharge procedures and protocols were put in place. This chapter argues that the PCG's locality-wide base positioned it well to facilitate better understanding of roles and to improve referral procedures around hospital discharge across the geographical area.

This chapter argued that some GPs and a PCG/T manager felt passionately that the shared care of drug users was a valuable area of work, but this view was not represented on the PCG/T governing bodies. Although a substance misuse services development officer was appointed, and the board eventually ratified proposals to introduce shared care for drug users, many of the board GPs were themselves hostile to the idea that heroin users should be treated in primary care so were not motivated to bring their GP colleagues with them in taking on this area of work. In this case, having clinicians on the governing body of the PCG was not effective in implementing 'official' PCG policy.

Individual doctors' resistance to working with drug users stemmed from issues related to levels of remuneration and fear of being overwhelmed by demand if "floodgates" were opened. The PCG/T's corporate reluctance to prioritise it derived from the fact that it were not centrally performance managed on substance misuse services, and the funding for it came not from their budget, but from the local Drug Action Team. The factor which was most effective in bringing GPs on board with shared care was the appointment of the 'specialist generalist.' Her identity as a former GP made her arguments were more persuasive to GPs than those of the PCG manager. She was also better able to influence the drugs workers.

However, **this section argues that** the managers and clinicians deviated significantly from their respective stereotypes. Managers did not always behave like "bean-counters." In the PCG, they were manifestly motivated by social justice and public-spiritedness. Controversy surrounding remuneration of GPs bore testament to the degree to which they were financially motivated. It also illustrated the contractual, rather than network-based, nature of collaborative working.

The inclusion of a local authority SSD representative on the PCG/T governing bodies was designed to facilitate closer working between primary care and social services on the planning and delivery of services. **This section argues that** the intermediate care services set up to reduce pressure on acute services

by reducing the number of hospital admissions amongst older people and to facilitate effective and timely discharge from hospital did not arise as a result of SSD representation on the governing bodies of the PCG/T, but were rather brought about by new collaborative relationships at senior levels of SSD and PCT management, and were facilitated by the Health Act Flexibilities.

Chapter eight: Discussion and conclusions

8.1 Overview

The overall aim of this study was to investigate whether and how the PCG and PCT developed, promoted, facilitated and enhanced collaboration within primary care and between it and other NHS and non-NHS bodies. It also aimed to identify the factors which enabled and inhibited its collaborative capacity. This was important for at least two reasons. First, PCGs and PCTs were a key element of New Labour's radical reforms of the NHS and held a pre-eminent position within the new collaborative agenda. They were expected to facilitate collaboration within elements of their primary care community, with other parts of the NHS and with other organisations whose work related to health in the broadest sense. Collaborative working was presented as a remedy for complex social problems and the fragmentation of public services. It was important that the effects of these initiatives were examined, particularly in the context of the third way emphasis on pragmatism and 'what works'.

Second, the effectiveness of these policy reforms were of theoretical as well as practical interest. New Labour explicitly distanced itself from Old Labour hierarchies and Conservative markets, while wedding their policies rhetorically to notions of altruism, trust and co-operation, the key characteristics of a network mode of governance. In doing so, they invited political scientists to draw and evaluate parallels between their 'third way' and a network mode of governance.

This chapter brings together the evidence and theory accumulated over the course of this study. **Section 8.2** draws together the key findings from the empirical research presented in chapters five, six and seven. From these, conclusions are drawn in relation to the two main research questions to evaluate Oxford City PCG and PCT as mechanisms for collaboration. It argues first that some aspects of organisational form facilitated collaboration for health improvement, and others for primary care development. Second, it argues that, on balance, the PCG was more effective than the PCT in bringing about collaboration aligned with a network mode of governance.

Factors which facilitated collaboration for health improvement were a policy environment conducive to tackling complex social problems, the organisation's explicit health improvement remit, coterminosity between the PCG and the City Council, and the work of skilled and committed boundary-spanners. The factors which facilitated collaboration for the development of primary care were the election of clinicians by their peers to the governing bodies and their collective responsibility for budget and clinical governance.

This section goes on to argue that organisational turbulence during the transition from PCG to PCT damaged nascent collaborative ventures initiated by the PCG. This was true particularly where they depended on individual boundary spanners whose roles were not continued from PCG to PCT, most frequently in upstream health improvement. The political context further compromised the collaborative capacity of the PCT where policy directives from central government undermined its rhetoric of collaboration based on trust and co-operation, and which were more resonant of hierarchical modes of governance.

Section 8.3 reconsiders the theoretical framework in the light of the evaluation of the PCG and PCT. This framework highlighted the influence of organisational form and contextual factors, particularly shifts in modes of governance, on organisations' collaborative capacity and practice. This section argues that the framework was supported by the findings, but suggests it be modified by accounting explicitly for the effects of organisational turbulence itself on collaborative capacity and practice.

The differences between the PCG's and PCT's form made for some differences in their respective collaborative capacity. However, the most radical features of the PCG's and PCT's organisational form (the locality-wide base, the election of clinicians to their governing bodies, local authority representation, and their responsibilities for clinical governance, budget and health improvement) were common to both. A greater difference between the two organisations was the national political context in which they operated. Over the course of the study, the association of New Labour policy with a quasi-network mode of governance became increasingly dubious. Despite maintaining a strong rhetoric of collaboration, Government policy undermined the development of policy networks suggesting symbolic politics.

Section 8.4 considers the strengths and limitations of the study. It reflects on the design and methodology of the study, and the implications of carrying out research in such a rapidly changing policy environment.

8.2 Critical evaluation of the PGC and PCT as mechanisms for collaboration

PCGs were established in 1999 with the policy objectives of developing primary care by working across practices, working collaboratively with a range of other organisations to improve the local population's health, and commissioning secondary care (Secretary of State for Health, 1997). Two of these remits - health improvement and primary care delivery and development - required collaboration between different groups and with different goals and purposes. They were expected to play a major role in "a move from primary medical care (general practice) to primary health care with a public health focus" (Peckham & Exworthy, 2003: 238).

PCG and PCT governing bodies included GPs, nurses and an SSD representative. They had to learn to apply managerial skills to areas which had traditionally been devoid of management, to create a sense of a single organisation working towards specific goals, and to co-ordinate disparate groups into a coherent organisation (Glendinning, 1998).

This case study of one PCG and PCT set out to answer the following key research questions:

RQ1. How far did Oxford City PCG and PCT act as collaborative mechanisms to develop and deliver primary care and to improve the health of their population?

RQ2: Which factors enabled collaboration to come about and which inhibited collaboration?

This section draws together the key findings from the empirical research presented in chapters five, six and seven. From these, conclusions are drawn in relation to the two main research questions to evaluate Oxford City PCG and PCT as mechanisms for collaboration. It argues first that different aspects of organisational form facilitated collaboration for health improvement than for primary care development. Second, it argues that, on balance, the PCG was

more effective than the PCT in bringing about collaboration aligned with a network mode of governance.

8.2.1 Factors which facilitated collaboration for health improvement in the PCG

As chapter five demonstrated, the composition of the PCG board was not an aspect of its organisational form which effectively facilitated collaboration for health improvement. The SSD representative board member did not act as a conduit between the PCG and parts of the local authority (City or County) whose remits were related to improving health. The domination of the board by practising clinicians neither lent credibility to the PCG's upstream health improvement work amongst their fellow clinicians in the city, nor brought about a shift from a medically-dominated to an upstream approach to health care.

The board endorsed a ringfenced budget for the HImP group, but took little active interest in it compared to their interest in financial and clinical governance matters. The general disengagement of the board GPs and the primary care community generally from the work of the HImP group, demonstrated that changes in organisational structures are not sufficient to bring about change to deeply embedded cultural values and practices. This finding is consistent with findings of Chinamasa et al (2002), who contend that primary care professionals struggle with the concepts involved in public health, and that the shift from a medical model-based approach to a broader population-based approach may create uncertainty and confusion. Heller et al (2002) identified a paucity of work on the public health role in primary care, and a need to build human resource capacity in public health at the primary care level.

One aspect of the PCG's form which was effective in facilitating collaboration was its explicit mandate to improve the health of its population, which bestowed credibility on previously less valued upstream approach to health. Oxford City PCG's HImP group took New Labour's rhetoric at its word and developed collaborative strategies for health improvement. This was reflected first in the PCG's adoption of its own local, outstandingly non-medical HImP priorities and the inclusive process by which they were identified. The operation of this group under the aegis of a mainstream NHS body gave their

sometimes quite radical health improvement work a legitimacy it had not previously enjoyed.

A second aspect of the PCG's form which was effective in facilitating collaboration was its locality-wide base, coterminous with the City Council. The PCG's coterminosity with the City Council facilitated collaboration with the parts of the local authority most in touch with their public health underpinnings. This gave rise to the joint funding of two health development managers (HDMs), which signalled a strong measure of shared vision and trust between the PCG and City Council, and a commitment to the goal of reducing health inequalities. The management structure of the locality-wide organisation supported the health improvement function and the HImP group and staff.

The combination of a mainstream NHS body's mandate for upstream health improvement, and its coterminosity with the City Council, was conducive to the activity of boundary-spanners. Strong links were developed and maintained by boundary-spanners between the PCG and the health promotion department of the City Council. The health development managers (HDMs) were highly effective at bridging organisational, sectoral and cultural divides to develop collaborative relationships based on trust, co-operation, loyalty and reciprocity.

Thus, even in the absence of clinician buy-in, collaboration for health improvement took place and, in many ways, the PCG HImP group and HImP activity was a model of network collaboration. A palpable sense of camaraderie pervaded the HImP group: its activities were based on the identification of complementary interests, and its internal and external relationships on trust and reciprocity. Following the initial departure of the GPs and chief executive, the HImP group maintained a loyal and committed membership which was maintained throughout the lifetime of the PCG and into the first months of the PCT.

A drawback to the voluntary, organic nature of these collaborative relationships was that they depended heavily on individual people acting as boundary-spanners. Where boundary-spanners did not operate, collaborative gaps occurred (for example, between the PCG and the housing department of the City Council) illustrating the unstrategic nature of the development of collaboration where it depended on the *ad hoc* presence of individual boundary-spanners.

8.2.2 Factors which facilitated collaboration for primary care development and delivery in the PCG

The inclusion of clinicians on the governing bodies of PCGs and PCTs was more effective for developing and delivering primary care than for health improvement. Board clinicians were very much more engaged with issues of clinical governance and budget than they were in the HImP process.

PCG/Ts' budgetary and clinical governance responsibilities introduced a new interdependency between GPs in a locality. In the PCG, policies for primary care were developed by clinicians who were elected by their peers, and were implemented through a facilitative processes which appeared not to be an unacceptable threat to doctors' professional autonomy. The closeness of the board members to their clinical constituencies made for an accessible and transparent local policy process. It proved to be an effective mechanism to influence GPs' spending and clinical practice, despite their independent contractor status and their long tradition of professional autonomy. An outcome of the collaboration was that the prescribing spend in primary care was reduced.

One area of primary care development with which the board GPs did not willingly engage was the development of substance misuse services. It was unattractive to them for various reasons as set out in chapter seven and they, therefore, did not endorse it amongst their colleagues in the city. Developing them was the responsibility of a non-clinical manager who understood the value of bringing in the support of other clinicians to act as ambassadors for the services. By the end of the study, 54 GPs signed up to shared care drugs services.

The processes of primary care delivery and development were based on a sense of mutual professional identity and were network-like in some respects. They were built on trust, reciprocity and a sense of corporacy and mutual responsibility.

8.2.3 The effects of organisational turbulence during the transition from PCG to PCT on collaboration

Although the Secretary of State for Health had proclaimed in 1997 that neither NHS staff nor patients had an appetite for more organisational change in the NHS, such change over the period of this study was almost ubiquitous. The transition from PCG to PCT meant a period of great organisational turbulence. The prolonged transition meant a period of great uncertainty for staff and even redundancies. The changes in organisational structure, in the composition of the working groups and in policy emphasis disrupted existing collaborative relationships, particularly in the area of health improvement.

> In a context where there exists considerable uncertainty, policy overload and major organisational turbulence, the process for implementing policy and reaching sustainable decisions are likely to become more difficult to put in place successfully. Sustainability is of particular concern when it comes to addressing inequalities in health, given the accumulation of disadvantage over the life course, and the time required to demonstrate changes in health outcomes. (Hunter & Killoran, 2004: 5).

Pressure was put on the PCT to prioritise the more downstream targets defined in the *NHS Plan* (Secretary of State for Health, 2000). Many of the elements of the PCG's HImP group work did not fit with these targets and were dropped from the agenda of the PCT's PH&I group. Upstream health improvement was further undermined by the departure of key boundary-spanners who were made redundant or moved away. The strongest thread of continuity from the PCG to the PCT was the clinicians, many of whom moved from PCG board to PCT PEC. As chapter five demonstrated, the PCG's upstream approach to health improvement was not embedded in the culture of these clinicians. Changes in policy and structure not only disrupted nascent collaborative relationships, but did considerable damage to the reputation of collaboration with non-statutory bodies whose trust was hard-won and had been painstakingly nurtured.

As chapter six showed, PCG board clinicians played a stronger role in primary care development and delivery than they had in health improvement. The

continuity of clinicians from PCG board to PCT PEC preserved some stability in this area of work. It was also less disrupted by central government policy.

8.2.4 Effects of changes in context on PCT's collaborative capacity

As chapter five showed, the PCG had many of the characteristics of an effective network collaboration, most notably in its health improvement work. The PCT's Public Health and Inequalities group composition, structures and processes changed almost beyond recognition in response to a context which bore a much closer resemblance to hierarchy than networks. The PCT's approach differed from the PCG's informal, organic collaborative ways as it developed more strategic relationships with the most senior level of other statutory organisations. Where an approach to health improvement is developmental and experimental promoting innovation to influence mainstream change:

> ...a command and control approach to policy and its delivery, pursued through vertically organised performance management and inspection arrangements, may be wholly inappropriate and run counter to the developmental ethos (Hunter & Killoran, 2004: 7)

The complexity of the PCT structure, the enhanced status of lay people and the separation of the board from the PEC suggested to threaten the status and influence of the elected health professionals. It rendered the organisation more bureaucratic and less responsive to local issues. It made it more difficult to nurture a sense of cohesion and common purpose and identity. The added organisational complexity distanced elected practitioners from their peers and threatened the sense in which clinicians felt they could influence and trust the PCT.

The differences between PCG's and PCT's collaborative capacity and practice can also be understood in terms of the shifts in the modes of governance, and the inconsistencies within central government policy. Rhetoric which promoted the tackling of complex social problems through the devolution of power to the front line suggested a network-like hands-off approach to governance. However, this was undermined by an increase in national targets, performance monitoring and central control.

Summary: This section drew together the key findings from the empirical research presented in chapters five, six and seven and drew conclusions in

relation to the two main research questions to evaluate Oxford City PCG and PCT as mechanisms for collaboration. It argued first that different aspects of organisational form facilitated collaboration for health improvement than for primary care development. Factors which facilitated collaboration for health improvement were a policy environment conducive to tackling complex social problems, the organisation's explicit health improvement remit, coterminosity between the PCG and the City Council, and the work of skilled and committed boundary-spanners. The factors which facilitated collaboration for the development of primary care were the election of clinicians by their peers to the governing bodies and the collective responsibility for budget and clinical governance.

Second, it argued that, on balance, the PCG was more effective than the PCT in bringing about collaboration aligned with a network mode of governance. Organisational turbulence damaged nascent collaborative ventures, particularly where they depended on individual boundary spanners whose roles were not continued from PCG to PCT, most frequently in upstream health improvement. The political context further compromised the collaborative capacity of the PCT where policy directives from central government undermined its rhetoric of collaboration based on trust and co-operation, and which were more resonant of hierarchical modes of governance.

8.3 Theoretical framework

This section reconsiders the theoretical framework in the light of the evaluation of the PCG and PCT. This study used a realist theoretical framework (figure 1), adapted from Sullivan & Skelcher (2002). The critical realist approach is in keeping with Pettigrew et al's (1992) call for research which is sensitive to the inner and outer context in which organisational change happens. Chapter two identified, as a key feature of the outer context, the resonance between New Labour's third way rhetoric and the defining features of a network mode of governance: trust, loyalty, reciprocity and voluntariness. Section 2.6 identified three broad tensions and contradictions within New Labour's collaborative policy: between voluntarism and imposed collaboration; between centralisation and devolution; and between the need for network

relationships to develop trust and loyalty over time, and the pace of organisational change within the NHS.

The findings chapters demonstrated that differences in form of the PCG and PCT made for some differences in collaborative capacity. However, the most radical features of the PCG's and PCT's organisational form (the locality-wide base, the election of clinicians to their governing bodies, local authority representation, and their responsibilities for clinical governance, budget and health improvement) were to some extent common to both. Over the course of the study, the alignment of the third way with a quasi-network mode of governance became increasingly tenuous. Despite maintaining a strong rhetoric of collaboration, New Labour policy undermined the development of policy networks. This wider political context accounted for significant differences between the PCG's and PCT's collaborative capacity and practice.

A feature which emerged strongly from the findings chapters, were the effects of organisational turbulence on collaborative capacity and practice. They may present opportunities for improved collaborative relationships, the case that was made for the more strategic relationships planned between the PCT and local authority. The study ended before they could be evaluated. However, the study demonstrated that the effects of staff turnover, uncertainty of strategic direction, additional bureaucracy, and the disruption of boundary-spanning activity had an adverse effect on collaboration. It also undermined the trust of voluntary organisations, and others who were not usually included by the mainstream, in the sincerity of NHS bodies' invitations to collaborate.

This study has demonstrated how organisational turbulence, along with tensions and contradictions in policy disrupted collaboration in practice. While ministers' formal commitment to upstream, collaborative approaches to public health became ever stronger, the conflicting forces of performance management and centralised policy making similarly increased. These conflicts and contradictions calls into question the sincerity of New Labour's efforts to align its third way discourse with a networks mode of governance. It suggests 'symbolic politics' were at work: that what was presented as a rational response to complex social problems and fragmentation of public services was in fact largely a pragmatic political manoeuvre designed to distance itself from the perceived failure of previous administrations' hierarchy and market modes of governance.

Summary: The theoretical framework highlighted the influence of contextual factors, particularly shifts in modes of governance, as well as organisational form, on organisations' collaborative capacity and practice. This section argued that the framework's emphasis on outer context was supported by the findings, but suggests that the framework be modified to account explicitly for the effects of organisational turbulence itself on collaborative capacity and practice.

8.4 Strengths and limitations of the study

Section 8.4 considers the strengths and limitations of the study. The implications of carrying out research in such a rapidly changing policy environment are considered. It reflects on the design and methodology of the study.

8.4.1 Design and methods

This case study provides a detailed account and analysis of collaboration within the Oxford City PCG and PCT. The use of a realist framework and multiple qualitative methods, allowed a detailed examination of the implementation of policy, allowing a rich and nuanced understanding of the interactions between changing organisational forms and rapidly shifting policy contexts.

The study of these two organisations and the process of transition between them allowed theoretical generalisations to be made about the effects of different contextual driving forces, and organisational change, for and against collaboration.

8.4.2 Effects of organisational change on the research process

It was clear from early stages of the study that the policy environment was likely to change over the course of the research, but I did not anticipate the pace of the changes. The shift from PCG to PCT nationally came about more quickly than was expected, and in Oxford the PCG, which had been the intended object of my study, became a PCT in April 2001. What set out as a case study of one organisation (a PCG) became a case study of two (the PCG

and the PCT). This opened up valuable opportunities for the comparison of two organisations and the process of organisational change, which became a strength of the study. The organisational context in which this research was carried out was short lived, but the findings have more enduring relevance.

However, another effect of the organisational turbulence was to make data collection more difficult. The PCG chief executive supported the study from the beginning and was prepared to negotiate my access to PCG subgroup meetings and to support my access to participants. Over time I developed a trusting relationship with people in the PCG and other local organisations. However, organisational change and the rapid turnover of staff meant my relationships with key staff were disrupted, and access to their successors (where they could be identified at all) was more difficult to negotiate.

8.4.3 Challenges of evaluating collaboration

Collaboration research has a tendency to focus on the process of collaboration, treating the collaborative mechanism as an end in itself. A strong argument can be made for the inclusion of outcome measures which reflect the benefits of collaboration (or lack of them) for service users (Dowling et al, 2004) in evaluations of collaboration if its purpose is to contribute to an evidence base to inform policy.

However, the challenges in identifying and measuring outcomes of collaboration are serious, and they are exacerbated in contexts of rapid organisational and policy change. Collaborative relationships take time to become established and, in cases where their aim is to improve health, the benefits are often diffuse and long term. The outcomes of collaborative ventures cannot be assessed if they are disrupted before they were expected to deliver. An absence of outcome evidence of success, therefore, does not necessarily signal an ineffective collaborative mechanism, but often reflect simply that outcomes had not come to fruition during the fieldwork period.

In a rapidly changing policy context, measuring outcomes which are distant and diffuse is not a viable way to evaluate collaboration. While bearing in mind that collaboration is not an end in itself, it is legitimate to measure collaborative processes which can reasonably be considered as precursors to outcomes. The case study design and multiple qualitative methods allowed a sensitive examination of the 'softer' elements of collaboration which can only

be understood through the analysis of in-depth generated and naturally occurring data.

References

Abbot, S & Gillam, S (2000) Health without a care, *Health Service Journal,* 2/11/2000: 32.

Abbot, S, Florin, D, Fulop, N & Gillam, S (2001) *Primary Care Groups and Trusts: Improving Health.* London: King's Fund.

Acheson, D (1998) *Report of the independent inquiry into inequalities in health.* London: HMSO.

Alter, C & Hage, J (1993) *Organisations working together.* London: Sage.

Anon (2001) UK Harm Reduction Association discussion list, 16 June 2001

Arnstein, S (1971) A ladder of participation, *Journal of the Royal Town Planning Institute,* 57: 176–182.

Audit Commission (1986) *Making a Reality of Community Care.* London: HMSO.

Audit Commission (1998) *A fruitful partnership: Effective partnership working.* London: Audit Commission.

Audit Commission (2000) *The PCG Agenda: Early Progress of Primary Care Groups in "The New NHS".* London: Audit Commission.

Audit Commission (2000a) *The way to go home: rehabilitation and remedial services for older people..* London: Audit Commission.

Bachmann, R (2001) Trust, power and control in inter-organizational relations, *Organization Studies,* 22 (2): 337–365.

Barnes, M, Hall, D, Leurs, R, McIver, S & Stewart, J (1997) *Citizen Participation: A Framework for Evaluation: Occasional Paper II.* Birmingham: School of Public Policy, University of Birmingham.

Bate, P (2000) Changing the culture of a hospital: from hierarchy to networked community, *Public Administration,* 78: 485–512.

Baum, F (1999) Social capital: is it good for your health? Issues for a public health agenda, *Journal of Epidemiology and Community Health,* 53 (4): 195–6.

Benson, JK (1975) The interorganisational network as a political economy, *Administrative Science Quarterly,* 20: 229–249.

Bevir, M & Rhodes, RAW (2001) Decentring Tradition: Interpreting British Government, *Administration and Society*, 33(2): 107–32.

Bhaskar, R (1978) *Realist theory of science.* Harvester: Wheatsheaf.

Bloxham, S (1996) A case study of inter-agency collaboration in the education and promotion of young people's sexual health, *Health Education Journal*, 55 (4): 389–403.

Bojke C, Gravelle, H & Wilkin, D (2001) Is bigger better for primary care groups and trusts? *British Medical Journal*, 322 (7286): 599–602.

Bond, M & Le Grand, J (2003) Primary Care Organisations And The "Modernisation" of the NHS, in Dowling, B & Glendinning, C, *The New Primary Care.* Maidenhead: Open University Press.

Borzel, TA (1998) Organising Babylon: on the different conceptions of policy networks, *Public Administration*, 76(2): 253–274.

Boulton, M & Fitzpatrick, R (1994) Qualitative methods for assessing health care, *Quality in Health Care*, 3: 107–113.

Bowling, A (2002) *Research Methods in Health.* Buckingham: Open University Press.

Bryman, A (1989) *Research Methods and Organization Studies.* London: Routledge.

Bryman, A (2001) *Social Research Methods.* Oxford: Oxford University Press.

Butterfoss, FD, Goodman, RM & Wandersman, A (1993) Community coalitions for prevention and health promotion, *Health Education Research*, 8: 315–30.

Callaghan, G, Exworthy, M, Hudson, B & Peckham, S (2000) Prospects for collaboration in primary care: relationships between social services and the new PCGs, *Journal of Interprofessional Care*, 14 (1): 19–26.

Campbell, SM, Sheaff, R & Sibbald, B (2002) Implementing clinical governance in English Primary Care Groups/Trusts: reconciling quality improvement and quality assurance, *Quality and Safety in Health Care*, 11(1):9–14.

Campbell S & Roland M (2003) Improving the quality of health care through clinical governance, in Dowling, B & Glendinning, C (eds.) *The New primary care: Modern, dependable, successful?* Maidenhead: Open University Press.

Casto, M (1994) Inter-professional work in the USA – education and practice, in Casto, M (ed.) *Going Interprofessional: Working Together for Health and Welfare.* London: Routledge.

Champlin, D (1999) Social capital and the privatization of public goods, *International Journal of Social Economics*, 26 (10/11): 1302–1314.

Charnley, H (2001) Promoting independence: a partnership approach to supporting older people in the community, in Balloch, S & Taylor, M (eds.) *Partnership working: Policy and practice.* Bristol: Policy Press.

Chinamasa, C, Edwards, R, & Heller, D (2002) *A report of synthesis of literature on the public health role of primary care in addressing health inequalities.* London: Health Development Agency.

Clarence, E & Painter, C (1998) Public Services under New Labour: Collaborative Discourses and Local Networking, *Public Policy and Administration*, 13: 8–22.

Clark, P & Bowling, A (1990) Quality of everyday life in long stay institutions for the elderly: An observational study of long stay hospital and nursing home care, *Social Science and Medicine*, 30: 1201–1210.

Clarke, J & Glendinning, C (2002) Partnership and the remaking of welfare governance, in Glendinning, C, Powell, M and Rummery, K (eds.) *Partnerships, New Labour and the Governance of Welfare.* Bristol: Policy Press.

Clarke, K & Rummery, K (2002) Partnership at the front line: the Well Family service and primary care, in Glendinning, C, Powell, M and Rummery, K (eds.) *Partnerships, New Labour and the Governance of Welfare.* Bristol: Policy Press.

Clarke, M & Stewart, JS (1997) *Partnership and the Management of Cooperation.* Birmingham: Institute of Local Government Studies, University of Birmingham.

Coleman, A & Glendinning, C (2002) Partnerships, in Wilkin, D, Coleman, A, Dowling, B & Smith, K (eds.) *The national tracker survey of primary care groups and trusts 2001/2002: Taking responsibility?* Manchester: National Primary Care Research and Development Centre.

Crawford, A (1998) *Crime Prevention and Community Safety: Politics, policies and practices.* Harlow: Longman.

Cropper, S (1996) Collaborative working and the issue of sustainability, in Huxham, C (ed) *Creating Collaborative Advantage.* London: Sage.

Dalley, G (1989) Professional ideology or organisational tribalism? in Taylor, R. and Ford, J. (eds.) *Social work and health care: Research highlights.* London: Jessica Kingsley.

Darlington, Y & Scott, D (2002) *Qualitative Research in Practice: Stories from the Field.* Maidenhead: Open University Press.

Davies, HTO & Harrison, S (2003) Trends in doctor–manager relationships, British Medical Journal, 326: 646–649.

Deeming, C (2004) Decentring the NHS: A Case Study of Resource Allocation Decisions within a Health District, *Social Policy and Administration*, 38(1): 57.

Degeling, P (1995) The significance of 'sectors' in calls for urban public health intersectoralism: An Australian perspective, *Policy and Politics*, 23(4): 289–301.

Delaney, F (1994) Muddling through the middle ground: theoretical concerns in intersectoral collaboration and health promotion, *Health Promotion International*, 9: 217–224.

Department of the Environment, Transport and the Regions (DETR) (2001) *Local strategic partnerships: government guidance.* London: Department of Environment, Transport and the Regions.

Department of Health (1998) *Primary care groups: Delivering the agenda. (HSC 1998/228: LAC(98)32).* Leeds: Department of Health.

Department of Health (1998a) *Partnerships in Action.* London: Department of Health.

Department of Health (1998b) *A First Class Service: Quality in the New NHS.* London: Department of Health.

Department of Health (1998c) *Modernising Health & Social Services: National Priorities Guidance.* London: Department of Health.

Department of Health (1999) *Reducing health inequalities: an action report.* London: Department of health.

Department of Health (1999a) *Primary Care Groups. The Government's response to the report of the Health Committee on Primary Care Groups.* London: Department of Health.

Department of Health (1999b) *Health of the Nation: A policy assessed.* London: HMSO.

Department of Health (1999c) *Drug Misuse and Dependence: Guidelines on Clinical Management.* London: HMSO.

Department of Health (1999e) *Modernising Social Services: promoting independence, improving protection, raising standards.* London: HMSO.

Department of Health (1999f) *Clinical Governance: Quality in the New NHS.* London: Department of Health.

Department of Health (1999g) *National Service Framework for Mental Health: Modern standards and service models* London: HMSO

Department of Health (2000) *Guidance on Joint Investment Plans.* London: Department of Health.

Department of Health (2000a) *National Service Framework for Coronary Heart Disease* London: HMSO

Department of Health (2001) *Shifting the Balance of Power: Securing Delivery.* London: Department of Health.

Department of Health (2001a) *Models of Care.* London: HMSO.

Department of Health (2001b) *National Service Framework for Older People.* London: HMSO.

Department of Health (2001c) *Shifting the balance of power within the NHS: Securing delivery.* London: Department of Health.

Dey, I (1993) *Qualitative data analysis.* New York: Routledge.

Dixon, J & Glennerster, H (1995) What do we know about fund-holding in general practice? *British Medical Journal,* 311: 727-730.

Dowling, B, Wilkin, D & Smith, K (2003) Organizational development and governance of primary care, in Dowling, B & Glendinning, C (eds.) *The New Primary Care: Modern, Dependable, Successful?* Maidenhead: Open University Press.

Dowling, B, Powell, M & Glendinning, C (2004) Conceptualising successful partnerships, *Health and Social Care in the Community,* 12 (4): 309-317.

Doyal, L & Cameron, A (2000) Reshaping the NHS workforce, *British Medical Journal,* 320: 1023-1024.

Drennan, VM (2004) *Clinicians as Leaders in Local NHS Governance Bodies: The Case of Primary Care Groups.* Ph.D. Thesis. London: King's College.

Edelman, M (1964) *The symbolic use of politics* Urbana: University of Illionois Press

Evans, D (2004) Shifting the balance of power? UK public health policy and capacity building *Critical Public Health* 14 (1): 51-63

Evans, D & Killoran, A (2000) Tackling health inequalities through partnership working, *Critical Public Health*, 10 (2): 125-40.

Exworthy, M & Halford, S (1999) *Professions and the New Managerialism in the Public Sector.* Buckingham: Open University Press

Exworthy, M, Powell, M & Mohan, J (1999) The NHS: Quasi-market, Quasi-hierarchy and Quasi-network? *Public Money and Management*, 19: 15-22.

Exworthy, M, Powell, M & Berney, L (2000) Big windows and little windows: Implementation under governance. *ESRC Seminar Series*, 23:page numbers?

Exworthy, M, Powell M, Berney L & Hallam E (2000) *Understanding health variations and policy variations.* Lancaster: Economic and Social Research Council Research Findings 5.

Fairclough, N (1989) Language and Power. London: Longman.

Ferlie, E (2002) What is known about effective approaches to managing strategic systems change and what are the implications for mainstreaming inequalities? London: Health Development Agency

Flynn, R, Williams, G, Pickard, S (1996) *Markets and Networks: Contracting in Community Health Services.* Bristol: Open University Press.

French, S (1993) Telling, in Shakespeare, P, Atkinson, D & French, S *(eds.) Reflecting on research practice: issues in health and social welfare.* Buckingham: Open University.

Friend, K, Power, JM & Yewlett, CJL (1974) *Public Planning: the Inter-Corporate Dimension.* London: Tavistock.

General Medical Council (1999) *Good Medical Practice.* London: General Medical Council.

Giddens, A (1998) *The Third Way: The renewal of social democracy.* Cambridge: Polity Press.

Gillam, S. (ed.) (2001) *What has New Labour done for Primary Care?* London: King's Fund.

Gillam, S, Abbott, S & Banks-Smith, J (2001) Primary care groups: Can primary care groups and trusts improve health? *British Medical Journal*, 323: 89-92.

Gillam, S & Florin, D (2002) Reducing health inequalities: primary care organisations and public health. London: Health Development Agency

Glendinning, C (1998) From general practice to primary care: development in primary care services 1990-1998, in Brunsdon, E, Dean, H & Woods, R (eds.) *Social Policy Review 10*. London: Social Policy Association.

Glendinning, C & Rummery, K (1997) *Working Together: Primary Care Involvement in Commissioning Social Care Services.* Manchester: NPCRDC.

Glendinning, C, Abbot, S & Coleman, A (2001) 'Bridging the Gap': New Relationships between Primary Care Groups and Local Authorities, *Social Policy & Administration,* 35 (4): 411-425.

Glendinning, C, Coleman, A, Shipman, C & Malbon, G (2001a) Primary Care Groups: Progress in Partnerships, *British Medical Journal,* 323: 28-31.

Glendinning, C, Coleman, A & Rummery, K (2003) Looking outwards. Primary care organizations and local partnerships, in Dowling, B & Glendinning, C (eds.) *The New Primary Care: Modern, Dependable, Successful?* Maidenhead: Open University Press.

Glendinning C & Dowling B (2003) Introduction: 'Modernizing' the NHS, in Dowling, B and Glendinning, C (eds.) *The New primary care: Modern, dependable, successful?* Maidenhead: Open University Press.

Gordon, P & Hanafin, T (1998) Hands across the divide, *Health Management*, October 1998: 20-21.

Habermas, J (1984) *Theory of communicative action volume 1: Reason and the rationalization of society* (trans. T. McCarthy). London: Heinemann.

Ham, C (1999) *Health policy in Britain: the politics and organisation of the National Health Service.* Basingstoke: Macmillan.

Hardy, B, Turrell, A & Wistow, G (1992) *Innovations in community care management.* Aldershot: Avebury.

Hardy, B, Hudson, B & Waddington, E (2000) *What makes a good partnership?* Leeds: Nuffield Institute for Health.

Harrison, S (2002) New Labour, modernisation and the Labour process, *Journal of Social Policy*, 31(3): 465-485.

Harrison, A (ed.) (1993) *From Hierarchy to Contract.* Newbury: Policy Journals.

Harrison, S & Pollitt, C (1994) *Controlling Health Professionals: The Future of Work and Organization in the National Health Service.* Philadelphia: Open University Press.

Hatch, MJ (1997) Relations between organizational culture, identity and image, *European Journal of Marketing,* 31 (5): 356 - 365.

Hayden, C & Boaz, A (2000) *Making A Difference: Better Government for Older People - Evaluation Report.* Coventry: Local Government Centre, University of Warwick.

Health Select Committee (1998) *The Relationship Between Health and Social Services.* London: HMSO.

Heller, D (2002) *How can primary care trusts develop and implement their public health roles to help reduce health inequalities?* Paper presented at the Health Development Agency seminar 'Tackling health inequalities', London, June 2002.

Heller, D (2002) Needs assessment of PCTs: supporting the public health and primary care agenda. London: Health Development Agency

Higgins, R, Oldman, C & Hunter, D (1994) Working together: lessons for collaboration between health and social services, *Health and Social Care,* 2: 269-277.

Hill, M (1997) *The policy process in the modern state.* London: Prentice Hall.

Himmelman, A (1996) On the theory and practice of transformational collaboration: Collaboration as a bridge from social service to social justice, in Huxham, C (ed.) *Creating collaborative advantage.* London: Sage.

Hiscock, J & Pearson, M (1999) Looking Inwards, Looking Outwards: Dismantling the "Berlin Wall" Between Health and Social Services? *Social Policy and Administration,* 33(2): 150-163.

Hoggett, P (1991) A New Management in the Public Sector, *Policy and Politics,* 19(4): 243-256.

Hoggett, P (1996) New modes of control in the public service, *Public Administration,* 74: 9-32.

Home Office (1998) *Tackling drugs to build a better Britain: the government's ten year strategy for tackling drug misuse.* London: UK Government

Hornsby-Smith, M (1993) Gaining access, in Gilbert, N (ed.) *Researching Social Life.* London: Sage.

Hudson, B (1987) Collaboration in Social Welfare: A Framework for Analysis, *Policy and Politics*, 15 (3): 175-182.

Hudson, B (1999) Joint commissioning across the primary health care-social care boundary: can it work? *Health and Social Care in the Community*, 7 (5): 358-366.

Hudson, B (1999a) Dismantling the Berlin Wall: developments at the health-social care interface, in Dean, H & Woods, R (eds.) *Social Policy Review 11*, 187-204. Luton: Social Policy Association.

Hudson, B (2000) Social Services and Primary Care Groups: A window of collaborative opportunity? *Health and Social Care in the Community*, 8 (4): 242-250.

Hudson, B, Hardy, B, Henwood, M & Wistow, G (1997) *Inter-agency collaboration: Final Report.* Leeds: Nuffield Institute for Health.

Hudson, B, Exworthy, M, Peckham, S & Callaghan, G (1999) *Locality partnerships: The early primary care group experience.* Leeds: Nuffield Institute for Health.

Hudson, B & Hardy, B (2002) What is a 'successful' partnership and how can it be measured? in Glendinning, C, Powell, M & Rummery, K (eds.) *Partnerships, New Labour and the Governance of Welfare.* Bristol: Policy Press.

Huggins, R (2000) *Heroin, Crack and Crime: The Oxford Perspective.* Oxford: Oxford Brookes University.

Hughes, J & Sharrock, W (1997) *The philosophy of social research.* London: Longman

Hunter, D., J. (2000) Managing the NHS. In Appleby, J., Harrison A, *The King's Fund Review of Health Policy*, Health Care UK, Winter, King's Fund: London, 69-76

Hunter, DJ (2003) *Public Health Policy.* Cambridge: Polity Press.

Hunter, DJ & Killoran, A (2004) *Tackling health inequalities: turning policy into practice?* London: Health Development Agency

Huxham, C (2000) The challenge of collaborative governance, *Public Management*, 2 (3): 337–357.

Huxham, C & Vangen, S (2000) Ambiguity, complexity and dynamics in the membership of collaboration, *Human Relations*, 53(6): 771–806.

Kemshall, H & Ross, L (2000) Partnerships in Evaluation: Modelling Quality in Partnership Projects, *Social Policy and Administration*, 34 (5): 551–566.

Kirk, J & Miller, ML (1986) *Reliability and validity in qualitative research.* London: Sage.

Le Grand, J (2002) Further Tales from the British National Health Service, *Health Affairs*, 21 (3):116–128.

Johansson, R & Borell, K (1999) Central steering and local networks: Old-age care in Sweden, *Public Administration*, 77 (3): 585–598.

Johnson, R (1987) What is cultural studies anyway? *Social Text: Theory/Culture/ Ideology*, 16: 38–80.

Jurkovich, R (1974) A Core Typology of Organizational Environments, *Administrative Science Quarterly*, 19 (3): 380–394.

Keen, J & Packwood, K (2000) Using case studies in health services and policy research, in Pope, C & Mays, N (eds.) *Qualitative research in health care*, 2nd edition. London: BMJ Publishing Group.

Klein, R (1998) Why Britain Is Reorganising Its National Health Service—Yet Again, *Health Affairs*, 17 (4): 111–125.

Klein, R (ed.) (1999) Implementing the white paper: pitfalls and opportunities. London: King's Fund Publishing.

Klein, R (2001) *The new politics of the NHS.* Harlow: Pearson Education.

Laidler, P (1991) Adults and how to become one, *Therapy Weekly*, 17 (35): 4.

Lane, C & Bachmann, R (2000) *Trust Within and Between Organizations: Conceptual Issues and Empirical Applications.* Oxford: Oxford University Press.

Langley, A (1999) Strategies for theorizing from process data, *Academy of Management Review*, 24 (4): 691–710.

Lazenbatt, A, Orr, J & O'Neill, E (2001) Inequalities in health: evaluation and effectiveness in practice, *International Journal of Nursing Practice*, 7: 383–391.

Legard, R, Keegan, J & Ward, K (2003) In-depth interviews, in Richie, J & Lewis, J (eds.) *Qualitative Research Practice: A guide for Social Science Students and Researchers.* London: Sage.

Lewis, J & Ritchie, J (2003) Generalising from qualitative research, in Richie, J & Lewis, J (eds.) *Qualitative Research Practice: A guide for Social Science Students and Researchers.* London: Sage.

Ling, T (2000) *Unpacking partnership:* the case of health care, in Clarke, J, Gerwitz, S & McLaughlin, E (eds.) *New Managerialism, New Welfare?* Thousand Oaks, CA: Sage.

Local Government Management Board (1996) *Survey of Community Safety Activities in Local Government in England and Wales.* London: Local Government Management Board.

Lowndes, V & Skelcher, C (1998) The dynamics of multi-organisational partnerships: an analysis of changing modes of governance, *Public Administration,* 76 (2): 313-334.

Luke, JS (1998) *Catalytic Leadership.* San Francisco: Jossey-Bass.

Mackian, S (2002) Complex cultures: rereading the story about health and social capital, *Critical Social Policy,* 22 (2): 203-225.

Mayer, RC, Davis, JH & Schoorman, FD (1995) An Integrative Model of Organizational Trust, *Academy of Management Review,* 20 (3): 709-734.

Mayo, M & Taylor, M (2001) Partnerships and power in community regeneration, in Balloch, S & Taylor, M (eds.) *Partnership working: Policy and Practice.* Bristol: Policy Press.

Mays, N & Pope, C (2000) Assessing quality in qualitative research, *British Medical Journal,* 320: 50-52.

Mays, N, Goodwin, N, Killoran, A & Malbon, G (1998) Total Purchasing: *A step towards primary care groups.* London: King's Fund

Meads, G & Killoran, A (1999) *Mixing oil and water: How can primary health care organisations improve health as well as deliver effective health care?* London: Health Education Authority.

Melia, KM (1997) Producing 'Plausible Stories': Interviewing Student Nurses, in Miller, G & Dingwall, R (eds.) *Context & Method in Qualitative Research.* London: Sage.

Miller, C & Ahmad, Y (2000) Collaboration and partnership: an effective response to complexity and fragmentation or solution built on sand? *International Journal of Sociology and Social Policy* 20: 1–38.

Mishler, EG (1986) *Research Interviewing: Context and Narrative.* London: Harvard University Press.

Molyneux, J (2001) Interprofessional teamworking; what makes teams work well? *Journal of Interprofessional Care,* 15 (1): 29–35.

Naidoo, J & Wills, J (1998) *Practising Health Promotion.* London: Bailliere Tindall.

National Health Service Executive (NHSE) (1998a) *The new NHS Modern and Dependable: Establishing Primary Care Groups. HSC 1998/065.* Leeds: Department of Health.

National Health Service Executive (NHSE) (1998b) *The new NHS: modern and dependable: developing primary care groups.* (HSC 1998/139). Leeds: National Health Service Executive.

National Health Service Executive (NHSE) (1998c) *Health Improvement Programmes: Planning for better health and better health care.* HSC 1998/167. Leeds: Department of Health.

National Health Service Executive (NHSE) (1999) 'primary care trusts: establishing better services 98C753/241. Leeds: Department of Health

National Health Service Executive (NHSE) (2001) Quality and performance in the NHS. Performance indicators: HSC 2000/023. Leeds: Department of Health.

NHS (Primary Care) Act (1997) Chapter 46. London: HMSO.

Newman, J (1994) Beyond the Vision: Cultural Change in the Public Sector, *Public Money and Management,* 14 (2): 59–64.

Newman, J (2001) *Modernising governance: New Labour, policy and society.* London: Sage.

Nocon, A (1994) *Collaboration in Community Care in the 1990s.* Sunderland: Business Education Publishers.

North, N, Lupton, C & Khan, P (1999) General practitioners and the new NHS, *Health and Social Care in the Community*, 7 (6): 408–16.

O'Hagan, G (1999) *Of Primary Importance: Inspection of Social Services Departments' Links with Primary Health Services – Older People*. London: Social Services Inspectorate, Department of Health.

Oxford City PCG HImP Group (1999) *Terms of reference.* Oxford: Oxford City PCG.

Oxford City PCG HImP Group (2001) HIMP Action Plan, Oxford: Oxford City PCG.

Oxford City Primary Care Development Group (September, 19999) Primary Care Investment Plan 1999-2002

Oxfordshire Drug and Alcohol Action Team (DAAT) (2002) *The Oxfordshire Approach: Shared care for drug misusers.* Oxford: Oxfordshire DAAT.

Øvretveit, J (1997) *Interprofessional working for health and social care.* London: Macmillan.

Paton, C (1999) New Labour's health policy, in Powell, M (ed.) *New Labour, new welfare state? The 'third way' in British social policy.* Bristol: Policy Press.

Patton, MQ (2002) *Qualitative research and evaluation methods.* Thousand Oaks, CA: Sage.

Pawson, R & Tilley, N (1997) *Realistic Evaluation.* London: Sage.

PCG chair (2000) in *Health in Oxford* newsletter, Dec 00/Jan 01

Peckham, S (2003a) Improving local health in Dowling, B & Glendinning, C. (eds.) *The New primary care: Modern, dependable, successful?* Maidenhead: Open University Press.

Peckham, S (2003b) Who are the partners in public health? In Orme, J, Powell, J, Taylor, P, Harrison, T & Grey, M (eds.) *Public Health for the 21st Century: New Perspectives on Policy, Participation and Practice.* Maidenhead: Open University Press, 2003: 59-78.

Peckham, S & Exworthy, M (2003) *Primary Care in the UK.* Bristol: Palgrave.

Pettigrew, A, Ferlie, E & McKie, L (1992) *Shaping Strategic Change: Making change in large organisations.* London: Sage.

Plamping, D, Gordon, P & Pratt, J (2000) Practical partnerships for health and local authorities, *British Medical Journal*, 320: 1723-1725.

Pollitt, C (1993) *Managerialism and the public services.* Oxford: Blackwell.

Pollitt, C, Harrison, S, Hunter, D & Marnoch, G (1990) No Hiding Place: On the Discomforts of Researching the Contemporary Policy Process, *Journal of Social Policy*, 19 (2): 169–190.

Popay, J (2001) *Evidence to House of Commons Select Committee on Health.* London: HMSO.

Pope, C, Ziebland, S & Mays, N (2000a) Analysing qualitative data, in Pope, C & Mays, N (eds.) *Qualitative Research in Health Care.* London: BMJ Publishing Group.

Pope, C, Ziebland, S & Mays, N (2000b) Observational methods in health care settings, in Pope, C and Mays, N (eds.) *Qualitative Research in Health Care.* London: BMJ Publishing Group.

Powell, M & Exworthy, M (2001) Joined-Up Solutions to Address Health Inequalities: Analysing Policy, Process and Resource Streams, *Public Money and Management*, 21 (1): 21–26.

Powell, M, Exworthy, M & Berney, L (2001) Playing the game of partnership, in Sykes, R, Bochel, C, & Ellison, N. (eds.) *Social Policy Review 13.* Bristol: Policy Press.

Powell, M & Exworthy, M (2002) Partnerships, quasi-networks and social policy, in Glendinning, C, Powell, M and Rummery, K (eds.) *Partnerships, New Labour and the Governance of Welfare.* Bristol: Policy Press.

Powell, M & Glendinning, C (2002) Introduction, in Glendinning, C, Powell, M and Rummery, K (eds.) *Partnerships, New Labour and the Governance of Welfare.* Bristol: Policy Press.

Poxton, R (1999) *Partnerships in Primary & Social Care: Integrating Services for Vulnerable People.* London: King's Fund.

Pratt, J (1995) *Practitioners and practices: a conflict of values?* Oxford: Radcliffe Medical Press.

Oxford City PCG (1999) *Primary Care Investment Plan 1999-2002* Oxford City PCG

Ranade, W (1998) *Making sense of Multi-Agency Groups – Research Report.* (Unpublished). Newcastle: Sustainable Cities Research Institute, University of Northumbria.

Regen, E, Smith, J & Shapiro, J (1999) *First off the starting block: Lessons from GP commissioning for primary care groups*. Birmingham: Health Services Management Centre.

Rhodes, R (1997) *Understanding Governance.* Buckingham: Open University Press.

Ring, PS & van de Ven, AH (1994) Developmental Processes of Cooperative Interorganizational Relationships, *The Academy of Management Review*, 19 (1): 90-118.

Ritchie (2003) The applications of qualitative methods to social research, in Richie, J & Lewis, J (eds.) *Qualitative Research Practice: A guide for Social Science Students and Researchers.* London: Sage.

Ritchie, J & Spencer, L (1994) Qualitative data analysis for applied policy research, in Bryman, A & Burgess, RG (eds.) *Analyzing Qualitative Data,* London: Routledge.

Ritchie, J & Lewis, J (eds.) (2003) *Qualitative Research Practice: A Guide for Social Science Students and Researchers.* London: Sage.

Rittel, HWJ &Webber, MM (1973) Dilemmas in a general theory of planning, *Policy Sciences* 4 (2): 155-169.

Robinson, J & Paxton, R (1998) Health and social care partnerships, in Robinson, J & Paxton, R (eds.) *Implementing the White Paper.* London: King's Fund.

Robinson, WS (1951) The logical structure of analytic induction, *American Sociological Review*, 16: 812-818.

Roethlisberger, FJ & Dickson, WJ (1939) *Management and the worker.* Cambridge, MA: Harvard University Press.

Rummery, K (1998) Changes in primary health care policy: The implications for joint commissioning with social services, *Health and Social Care in the Community,* 6 (6): 429-438.

Rummery, K (2002) Towards a theory of welfare partnerships, in Glendinning, C, Powell, M and Rummery, K (eds.) *Partnerships, New Labour and the Governance of Welfare.* Bristol: Policy Press.

Rummery, K & Coleman, A (2003) Primary health and social care services in the UK: progress towards partnership? *Social Science and Medicine*, 56: 1773–1782.

Sako, M (1992) *Price, quality and trust.* Cambridge: Cambridge University Press.

Salter, B (1998) *The politics of change in the health service.* Basingstoke: Macmillan.

Saltman, RB & von Otter, C (1992) *Planned markets and public competition: strategic reform in northern European health systems.* Philadelphia: Open University Press.

Secretary of State for Health (1997) *The New NHS: Modern, dependable* Cm3807 London: HMSO

Secretary of State for Health (1998) *Modernising Social Services* London: HMSO

Secretary of State for Health (1998) *Our Healthier Nation* Cm 3582 London: HMSO

Secretary of State for Health (1999) *Saving Lives* Cm 4386 London: HMSO

Secretary of State for Health (2000) *The NHS Plan: A plan for Investment, a Plan for Reform, Cm 4818-I.* London: HMSO.

Shapiro, J (2001) Soft changes, hard work, *Health Service Journal*, 111 (5744): 22.

Sheaff, R, Marshall, M, Rogers, A, Roland, M, Sibbald, B & Pickard, S (2004) Governmentality by network in English primary healthcare. *Social Policy & Administration*, 38(1) 89–103

Sibbald, B, Petchey, R, Gosden, T, Leese, B & Williams, J (2001) *Salaried GPs in PMS pilots: Impact on recruitment, retention, working practices and quality of care.* Manchester: NPCRDC

Silverman, D (2000) *Doing Qualitative Research: A practical handbook.* London: Sage.

Silverman, D (2001) *Interpreting qualitative data.* London: Sage.

Skelcher, C (2000) Changing images of the state: Overloaded, hollowed out, congested, *Public Policy and Administration*, 15 (3): 3–19.

Smart, C (1984) *The ties that bind: law, marriage and the reproduction of patriarchal relations.* London: Routledge & Kegan Paul.

Smith, K, Coleman, A, Dowling, B & Wilkin, D (2002) Organisational development and governance, in Wilkin, D, Coleman, A, Dowling, B & Smith, K (eds.) *The National Tracker Survey of Primary Care Groups and Trusts 2001/2002: Taking Responsibility.* Manchester: University of Manchester.

Snape, D & Spencer, L (2003) The foundations of qualitative research, in Ritchie, J & Lewis, J (eds.) *Qualitative Research Practice: A Guide for Social Science Students and Researchers.* London: Sage.

Spencer, L, Ritchie, J & O'Connor, W (2003) Carrying out qualitative analysis, in Ritchie, J & Lewis, J (eds.) *Qualitative Research Practice: A Guide for Social Science Students and Researchers.* London: Sage.

Statham, D (2000) Guest editorial: partnership between health and social care, *Health and Social Care in the Community,* 8 (2): 87–89.

Stinchcombe, AL (1965) Social structure and organizations, in J. March (ed) *Handbook of Organizations.* Chicago: Rand McNally

Stoker, G (1997) Local political participation, in R. Hambleton and associates (eds.) *New perspectives on local governance.* York: York Publishing Services.

Sullivan, H & Skelcher, C (2002) *Working across boundaries: Collaboration in public services.* Basingstoke: Palgrave MacMillan.

Taylor, P, Peckham, S & Turton, P (1998) *A public health model of primary care: from concept to reality.* Birmingham: Public Health Alliance.

Thompson, G, Frances, J, Levacic, R & Mitchell, J (1991) *Markets, hierarchies, networks: The co-ordination of social life.* London: Sage.

Thompson, JD (1967) *Organisations in actions.* New York: McGraw-Hill.

Trevillion, S (1991) *Caring in the Community.* London: Longman.

Tudor-Hart, J (1998) Our feet set on a new path entirely, *British Medical Journal,* 317: 171–172.

Walsh, K (1995) *Market mechanisms in the public sector.* Basingstoke: Macmillan.

Wanless, D (2002) *Securing our Future Health: Taking a Long-Term View* London: HM Treasury

Webb, A (1991) Co-ordination: a problem in public sector management, *Policy and Politics*, 19 (4): 229-241.

Wilkin, D, Gillam, S & Leese, B. (eds.) (2000) *The national tracker survey of primary care groups and trusts: progress and challenges 1999/2000.* Manchester: National Primary Care Research and Development Centre, King's Fund.

Wilkin, D, Gillam, S & Smith, K (2001) Tackling organisational change in the new NHS, *British Medical Journal*, 322: 1464-1467.

Wilkin, D, Coleman, A, Dowling, B & Smith, K (eds.) (2002) *The National Tracker Survey of Primary Care Groups and Trusts 2001/2002: Taking Responsibility.* Manchester: University of Manchester.

Williams, P. (2002) The competent boundary spanner. *Public Administration* 80 (1): 103- 124

Williamson, V (2001) The potential of project status to support partnerships, in Balloch, S & Taylor, M (eds.) *Partnership working: Policy and practice.* Bristol: Policy Press.

Wistow, G & Hardy, B (1996) Competition, collaboration and markets, *Journal of Interprofessional Care*, 10 (1): 5-10.

World Health Organisation (1985) *Targets for Health for All.* Copenhagen: WHO Regional Office for Europe.

Zald, MN & Berger, M (1978) Social movements in organisations: Coup d'etat, insurgency and mass movements *American Journal of Sociology* 83(4): 823-861

Appendices

Appendix 1: Sample letters of invitation

Oxford City Primary Care Group:
A case study of interagency collaboration
Principal Researcher: Alison Chisholm
AQREC Study Number: A00.036

[name]
Practice Manager
[name] Health Centre
[address]
Oxford

2 August 2000

Dear [name]

Further to our telephone conversation this morning, I am sending you some written information about the study in which the staff at [name] Health Centre are invited to take part. I would be very grateful if you would bring it to the staff's attention at your practice meeting on 14 August.

I am a PhD research student in the School of Social Sciences and Law at Oxford Brookes University, studying the impact of Oxford City Primary Care Group on interagency collaboration. The project will last for three years, and has the support of Oxfordshire Health Authority, Oxfordshire County Council and Oxford City Council as well as the full co-operation of the PCG itself. It is expected to assist policy development in the city and to help evaluate the impact of the HImP.

I would like to interview a range of professionals from the practice including, ideally, at least one **GP**, a **practice nurse**, a **community nurse** (if any are attached to the practice) and a **receptionist**. My research focuses on two of the City PCG's HImP priorities: **promoting independent living in older people** and **tackling substance misuse**, so I would be particularly keen to talk to anyone with an interest in either of these issues.

Interviews will take place over the next two months and the interview schedule would be sent in advance. Broadly speaking, I would like to ask about the impact of the PCG to date and its potential strengths, weaknesses, opportunities and threats, especially in relation to joint working with other health and social care organisations.

I appreciate that health professionals are very stretched so I would negotiate a time and place convenient to the interviewee and aim to keep each interview to half an hour.

Thank you very much for giving this project your consideration. As we agreed, I will call you again after 14th August to collect the names of any interested staff members

before I contact them directly. If you or they have any queries in the meantime, my telephone number is Oxford 484942, or you can email amchisholm@brookes.ac.uk.

I look forward to speaking to you again.

Yours sincerely,

Alison Chisholm
Research Student

[Name]
Housing and Revenue Department
Oxford City Council
St Aldates Chambers
Oxford
OX1 1DS

8 March 2000

Dear [name],

Further to our telephone conversation this morning, I am sending you some written information about the study in which you are invited to take part.

I am a CASE research student at Oxford Brookes University, studying the impact of Oxford City Primary Care Group on interagency collaboration. The project will last for three years, and has the support of Oxfordshire Health Authority, Oxfordshire County Council and Oxford City Council as well as the full co-operation of the PCG itself.

As you know, one of the City PCG's stated priorities, in accordance with the HImP, is to promote independent living in older people. The study will focus on people who have had a hip fracture. Care provision for these people potentially involves the whole system of health and social care and the involvement of many organisations, so if the PCG is to have an impact on interagency collaboration, it should be apparent in the treatment of this care group.

I plan to interview people from a range of agencies and organisations whose work concerns older people in Oxford, between April and June this year and again in the spring of 2001, to monitor the impact of the PCG on interagency collaboration from a variety of perspectives. I would very much like to talk to you about the way housing services are currently provided for older people, how the PCG engages other organisations, and the likely impact and actual impact of the PCG on their care from your point of view as Head of Strategic Housing Services. If you agreed to take part in the study, the interview schedule would be sent to you in advance, and I anticipate that the interview should take no more than an hour. With your permission I would like to tape record it, on the understanding that no-one outside the research team will listen to the recording.

Thank you very much for giving this project your consideration. I will follow this letter with a phone call in about a week. If you would like to take part in the study we can arrange a mutually convenient date and time for the interview. If you have any queries in the meantime, please do not hesitate to contact me; my number is Oxford 484942, or you can email amchisholm@brookes.ac.uk.

I look forward to speaking to you again.

Yours sincerely,

Alison Chisholm
Research Student

Appendix 2: Sample interview schedule & covering letter

Oxford City Primary Care Group:
A case study of interagency collaboration
Principal Researcher: Alison Chisholm
AQREC Study Number: A00.036

[Name]
Health Development Manager
Oxford City PCG
Warneford Hospital
Warneford Lane
Oxford
OX3 7JX

6th February 2001

Dear [Name],

Thank you very much for agreeing to take part in the study. I enclose an information sheet and a consent form (which I would ask you to bring with you when we meet), as well as an outline of the areas I would like to cover during the interview. This is intended as a guide to be picked from rather than as a prescriptive list of issues to be discussed. I appreciate that your time is precious so I will aim to limit the interview to 45 minutes.

The project is an evaluation of Oxford City PCG, focusing particularly on interagency collaboration. It will monitor its progress through two of the city's HImP priorities: promoting independent living in older people and tackling substance misuse.

The purpose of this interview is to explore:
the extent of partnership working that exists between different professions and organisations
the barriers to, and benefits of, such joint working
the impact of the PCG on partnership working

The study will continue over three years, and I plan to conduct follow-up interviews next year to examine whether and how the PCG/T has changed the nature of collaboration between primary care and other organisations. With your permission I would like to tape record the interview, on the understanding that no-one outside the research team will listen to the recording.

If you have any questions about the interview, or would like to speak to me before it, you can contact me on Oxford 484942. I look forward to seeing you at **9.30am on Wednesday 14th February.**

With best wishes,

Alison Chisholm
Research Student

Areas for discussion

- Existing links between the city PCG and other organisations whose work is relevant to the HImP process

- Structures in place to facilitate joint working

The HImP Group – membership, accountability, and the influence of its meetings and policies

- Benefits of and barriers to joint working (e.g. language, geography, culture, priorities, seamlessness, etc)

- Effect of organisational change on joint working

- The influence of the history and experience of individual staff members on progress in joint working

- A shift in the culture of primary care?

- Potential strengths, weaknesses, opportunities and threats of a PCT

Appendix 3: Sample information sheet

Information sheet

Oxford City Primary Care Group: Addictions Service.
Principal Researcher: Alison Chisholm

You are being invited to take part in a research study. Before you decide, it is important that you understand why it is being done and what it will involve. Please take time to read the following information carefully and discuss it with your relatives, friends and GP if you wish. If there is anything that is not clear, or if you would like more information, please ask. Take time to decide whether or not you would like to take part.

This study is part of a larger 3-year independent research project being carried out at Oxford Brookes University, to evaluate Oxford City Primary Care Group (PCG). The PCG is led by a board of GPs and community nurses, a lay member, Oxfordshire Social Services and Oxfordshire Health Authority. PCGs are expected to work in partnership with local councils, the social services and voluntary organisations (like Libra) so that the care and support people receive is improved.

One of the PCG's priorities is to address problematic drug use in the city. It is in the early stages of setting up a community drugs service for Oxford. This study will explore how appropriate the service is from the perspective of the service user, and how well organisations are working together to ensure that the user's journey through treatment and support is simplified.

You have been chosen because we are interested in the experiences of people who already use drugs agencies. Another five people will also be interviewed.

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. This will not affect the standard of care you receive.

Taking part would involve one interview which should last between 20 minutes and an hour. A researcher would interview you at Libra. She would ask you questions about your experiences and perceptions of the support you have received from any agencies you have come into contact with in relation to your drug use.

The interview would, with your permission, be tape-recorded. This recording would be heard by the research team and no-one else. When the report is written up, nothing you said would have your name attached to it and no-one would be able to identify you from it.

The results of the research will be published in 2002. If you would like to receive a summary of the findings of this part of the study, we will be happy to send you one.

If you would like any more information about the study, please contact Alison Chisholm at Oxford Brookes University on 01865 484941.

Thank you for reading this.

Appendix 4: Sample consent form

Oxford City Primary Care Group:
A case study of interagency collaboration.
Principal researcher: Alison Chisholm
AQREC study number: A00.036

CONSENT FORM

I have read and understood the information sheet for the above study. I have had the opportunity to ask questions about the study and have received satisfactory answers to them. ☐

I agree to take part in the above study. I understand that my participation is voluntary and I am free to withdraw at any time, without giving any reason. ☐

I agree that the interview may be tape recorded, and that any words I say during the interview can be used, anonymously, in the presentation of the research. ☐

_____	_____	_____
Name of participant	date	signature

_____	_____	_____
Researcher	date	signature

Appendix 5: List of participants

PCG/PCT

PCG chief executive

PCT chief executive

PCG board/ PCT PEC chair

PCG board/PCT PEC nurse

PCG board/PCT PEC GP

PCG/PCT lay member

Health development manager 2

Health development manager 1

PCG Substance misuse services development officer

Non-PCG/T clinicians

GP 1

GP 2

GP 3

GP 4

GP 5

GP 6

GP 7

CHT Community Development Nurse

District nurse 1

District nurse 2

District nurse 3

District nurse 4

Health visitor 1

Health visitor 2

Health visitor 3

Practice nurse

Joint Investment Plan co-ordinator

Outreach Occupational Therapist

Domiciliary physiotherapist

CRS physiotherapist

ICSS liaison nurse

City Council

City Council Officer: health promotion

City Council Officer: housing

City Council Officer: social inclusion

Social Services Department

SSD Care Manager 1

SSD Care Manager 2

Social Services hospital Unit Manager

PCG SSD Link

Voluntary sector

Carers' Centre Manager

Director of Age Concern, Oxfordshire